Managing Risk in a Culture of Rights: Providing Support and Treatment in Community-Based Settings for Persons with Intellectual Disabilities who Sexually Offend

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Abstract

People with intellectual disability who sexually offend commonly live in community-based settings since the closing of all institutions across the province of Ontario. Nine (n=9) front line staff who provide support to these individuals in three different settings (treatment setting, transitional setting, residential setting) were interviewed. Participants responded to 47 questions to explore how sex offenders with intellectual disability can be supported in the community to prevent re-offenses. Questions encompassed variables that included staff attitudes, various factors impacting support, structural components of the setting, quality of life and the good life, staff training, staff perspectives on treatment, and understanding of risk management. Three overlapping models that have been supported in the literature were used collectively for the basis of this research: The Good Lives Model (Ward & Gannon, 2006; Ward et al., 2007), the quality of life model (Felce & Perry, 1995), and variables associated with risk management. Results of this research showed how this population is being supported in the community with an emphasis on the following elements: positive and objective staff attitude, teamwork, clear rules and protocols, ongoing supervision, consistency, highly trained staff, and environments that promote quality of life. New concepts arose which suggested that all settings display an unequal balance of upholding human rights and managing risks when supporting this high-risk population. This highlights the need for comprehensive assessments in order to match the offender to the proper setting and supports, using an integration of a Risk, Need, Responsivity model and the Good Lives model for offender rehabilitation and to reduce the likelihood of re-offenses.

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Acknowledgments

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Brief History of Disability

The way in which people with disabilities tend to be treated in society relates to various social factors including cultural intolerance that has been attributed to a deep-rooted psychological fear of the unknown, the atypical, and those who evidence "difference" (Barnes, 2010). Examples of prejudice against people with disabilities can be found in religion, Greek philosophy, and European drama and art since before the time of the Renaissance. Throughout the Middle Ages in Europe, people with disabilities were the subjects of superstition, persecution and rejection, and were associated with demon possession and witchcraft. They were forced to enter institutions and asylums to live for the rest of their lives. The motivation behind the purification and segregation of people with disabilities was masked as being merciful and compassionate when essentially it served to make them appear non-existent for a fearful and prejudiced society (Owen, Griffiths, Tarulli, & Murphy, 2009). In the 19th century, there was a growing concern that people with disabilities posed a serious threat to the moral foundation of America, which was best controlled through segregation in feebleminded communities (Trent, 1994). The emergence of Social Darwinism reinforced this notion and dispelled the doubts of the rich and healthy through promotion of the idea that evolutionary progress would be promoted if only the fit were to survive. This doctrine led to the eugenics movement and the mass sterilization of people with disabilities in order to purify the human race and eliminate predispositions to disability (Barnes, 2010).

People with disabilities and challenging behaviour were institutionalized and subjected to lobotomies, shock therapy, and medical experiments (Braddock & Parish, 2001). This treatment was similar for people with disabilities who displayed challenging behaviour in deviant sexual

ways. For those who displayed sexually inappropriate behaviour, treatment aims have historically been restrictive rather than rehabilitative. More recently towards the end of the 20th century, people with disabilities and sexually inappropriate behaviour were treated with highly intrusive methods such as, "facial screening, overcorrection, the use of contingent lemon juice, and time-out" (Griffiths, Quinsey, & Hingsburger, 1989, pp. 9-10). Many of these individuals have grown up segregated in institutions that did not provide proper cultural expectations or appropriate role models and learning environments to the individuals (Griffiths et al., 1989). Therefore, challenging and inappropriate sexual behaviours were ignored or left untreated, as people were confined to institutions and these behaviours were seen as a normal part of institutional living. With widespread deinstitutionalization and the movement towards community living, there is an increase in people with intellectual disabilities who display these challenging and inappropriate sexual behaviours in the community (Hingsburger, Dalla-Nora, & Tough, 2010).

This increase in deviant sexual behaviour being present in the community has led to a growing area of research that aims to prevent, treat, and understand these behaviours. One aspect of the literature focuses on categorizing people with deviant sexual behaviour based on type of offender.

Typology of Offenders

Authors such as Day (1997) have distinguished between two types of offenders within the population with intellectual disabilities: Type I and Type II. Type I offenders are similar to offenders in the general population who have sexual deviance such as a form of paraphilia. On the other hand, Type II offenders display behaviour that is sexually inappropriate on the surface but is not a result of sexual deviance. The inappropriate sexual behaviours are not motivated by recurring urges or fantasies that typify paraphilia, rather they can be explained by underlying,

non-deviant factors. A concept that provides additional hypotheses for inappropriate sexual behaviour is counterfeit deviance (Hingsburger, Griffiths, & Quinsey, 1991).

Counterfeit deviance does not deny that paraphilia and deviance exist but instead recognizes that there are offenders with intellectual disability whose typography of behaviour appears sexually deviant but upon further investigation is a result of other factors. There are 11 hypotheses that can explain certain offending behaviour. The hypotheses are: structural, behavioural, modelling, partner selection, inappropriate courtship, sexual knowledge, perpetual arousal, learning history, moral vacuum, medical, and medication side effects.

The field is currently in a debate over the concept of counterfeit deviance (Griffiths, Hingsburger, Hoath, & Ioannou, 2013; Lunsky, Frijters, Griffiths, Watson, & Williston, 2007; Michie, Lindsay, Martin, & Grieve, 2006; Talbot & Langdon, 2006). In recent years, researchers have examined the socio-sexual knowledge of people with intellectual disability who sexually offend and concluded that these individuals do not have less knowledge than non-offenders (Talbot & Langdon, 2006) and indeed that persons with intellectual disabilities who sexually offend demonstrate significantly more sexual knowledge than a control group (Michie et al., 2006). Although the findings from the above articles at first appear to dispute the theory of counterfeit deviance in that the persons with intellectual disabilities did not offend because of a lack of sexual knowledge, their findings are not inconsistent with the theory.

Griffiths and colleagues (2013) note that the theory of counterfeit deviance never proposed that all sex offenders with intellectual disabilities had poor sexual knowledge, nor that someone with an intellectual disability with poor sexual knowledge will sexually offend. What it did propose was that a sexual offense could possibly occur because of poor sexual knowledge, and that it was possible to have deviant arousal and good sexual knowledge. Hence, a lack of

sexual knowledge is not a definitive path to sex offending, rather an area worth exploring when determining treatment (Griffiths et al., 2013)

The above point was illustrated by Lunsky and colleagues (2007) who reported similar results. They measured the knowledge and attitudes of 48 male individuals with an intellectual disability and sexual offense histories and compared it to a matched control sample group. The authors split the sex offending participants into one of two groups: Type I offenders were described as, "paedophiles, rapists or as having engaged in repeated or forced sexual assaults" (Lunsky et al., 2007, p. 76) and Type II offenders had engaged in "inappropriate touching, public exhibitionism or public masturbation" (p. 76). The authors found that not only did Type I offenders have more sexual knowledge than non-offenders but also that Type II offenders showed no significant difference in knowledge compared to the non-offender group. A study by Lockhart, Guerin, Shanahan, and Coyle (2010) found similar results and concluded that, "in relation to sexual knowledge, the current study did not uphold the hypothesis that individuals with sexualized challenging behaviour would have the lowest levels of sexual knowledge" (p. 127). However, given the dynamic relationship between knowledge and offending, it is important to note that while lack of knowledge does not necessarily lead directly to offending, it may be a contributing factor in the Type II sub-group whose behaviours are inappropriate rather than offending.

Although there is a lack of empirical research supporting the hypotheses of counterfeit deviance specifically, there is ample research in the literature that indirectly supports these hypotheses (Griffiths et al., 2013). The distinctions between offenders raised by Hingsburger and colleagues (1991) and supported by Lunsky and colleagues (2007) are consistent with Day's (1997) suggestion that there are two types of offenders with intellectual disabilities. Day (1997) noted that sexual offenses committed by persons with intellectual disabilities are typically more

"minor or nuisance offenses" (p. 279). He suggests that many of the offenses, such as indecent exposure, represent an inappropriate expression of sexual feelings rather than a sexual deviance (Day, 1997). Day (1997) similarly does not deny the existence of paraphilia within the population of intellectual disabilities, rather cautions for differentiation.

The above debate illustrates the potential of differentiating between deviance and counterfeit deviance as an important distinction to make in order to assist a clinician in determining appropriate treatment and asking the proper questions (Griffiths et al., 2013). In addition to counterfeit deviance, there is another important distinction to make in the typology of offenders with intellectual disability that has been incorporated into assessment and treatment. This includes the different pathways of offending described by Ward and Hudson in 1998.

Lindsay (2009) describes the four pathways presented by Ward and Hudson (1998) that can categorize offenders: approach/explicit, approach/automatic, avoidant/active, and avoidant/passive. The approach/explicit pathway model encompasses those offenders who have a clear, strong desire to sexually offend and use detailed plans and procedures to carry it out. The approach/automatic pathway describes offenders who display, "over-learned behavioural scripts which result in a more passive set of routines that are consistent with sexual offending" (Lindsay, 2009, p. 165). Thus, as reported by Lindsay (2009) it appears that offenders in the approach/automatic pathway do not show any premeditated plans to sexually offend, but rather they have a history of reinforcement for this behaviour so when the antecedent is present they are likely to act on it. The former two approach pathways are more common in people with intellectual disabilities. The third pathway is avoidant/active where the individual does not want to sexually offend as they actively try to control their thoughts and behaviours that may lead to offending. However, the strategies used are ineffective or counterproductive which leads to a sex offense. Avoidant/passive is the last pathway where the individual wants to avoid sexual

offending but they lack skills such as coping skills or social skills to prevent this from occurring (Lindsay, 2009).

These categories are important to consider in a thorough assessment in order to tailor treatment to the individual, as well as set up the appropriate setting that best suits the person's needs and prevents high-risk behaviours. Not all offenders present with the same risks, so the type of environment that they require can be vastly different depending on the nature of the offender. This highlights the importance of matching the offender to the appropriate setting; an approach/explicit offender will not require the same level of supervision and environmental controls as an avoidant/passive offender who may only offend if certain antecedents or dynamics are presented. The offender's styles of interpersonal relations and management of sexual urges and behaviour need to be seen as an interactive relationship in conjunction with other factors that influence sex offending, such as risk and protective factors.

Risk Factors of Sex Offending

A significant challenge for community service providers is the management of individuals who have committed sexual offenses to ensure that they do not reoffend. Research has indicated relatively high prevalence and recidivism rates of offenders with intellectual disabilities. Klimecki, Jenkinson, and Wilson (1994) reported an overall re-offending rate of 41.3% in prison inmates with intellectual disability and 34% recidivism rate for sex offenders at a two-year follow-up. More recently in a review of treatment services for sex offenders with intellectual disability, Lindsay and colleagues (2002) found that 4% of sex offenders with intellectual disability reoffended within the first year and 21% at four years. Using Klimecki and colleagues' (1994) re-offense rate of 34% at two years, and Lindsay and colleagues' (2002) re-offense rate of 21% at four years, Craig and Hutchinson (2005) estimated that the re-offense rate for sex offenders with intellectual disability is 6.8 times that of sex offenders without intellectual

disability at two years, and 3.5 times that at four years follow-up. However, McGrath, Livingston, and Falk (2007) present much different re-offense rates in their study. Over an average follow-up period of 5.8 years, they found a re-offense rate of 10.7% in a sample of male sex offenders with an intellectual disability which is much lower than the findings of the above studies.

Lastly, Johnson (2008) conducted a retrospective study examining a group of 86 sex offenders with intellectual disability and provided data on their rates of recidivism. Out of 63 men who received treatment, six (9.5%) reoffended, and the outcome for 11 others, or 17.5%, was not reported. This finding suggests that 46 men (73%) had not reoffended over a mean of 4.79 years. Interestingly, none of the nine individuals with diagnoses of pedophilia had reoffended (Johnson, 2008). This latter finding raises questions about the types of supports these individuals have received in order to refrain from reoffending.

The variation in the reported rates of sex offense prevalence makes it difficult to draw firm conclusions. However, the inconsistencies may be due to methodological issues such as inclusion criteria, source of the sample, and the method of determining intellectual disability (Lindsay, 2002). This difference may also be attributed to different approaches in the supporting environment. The nature of the environment in which a person lives post treatment may represent an important factor in the research on risk factors.

Researchers have determined there to be a number of possible factors associated with sex offending as a way to target the primary motivations and lead to a clear model of treatment. Some of the factors that have been found to relate to sex offending include personality disorders (Morrisey & Lindsay, 2003), childhood sexual abuse, sexual deviance (Lindsay, 2005), and low IQ (McCurry et al., 1998).

Research in the area of identifying risk factors for reoffending has focused on dynamic and static variables. Static risk factors are historical, generally unchangeable indicators of risk that represent behaviours or conditions that have happened or existed in the person's past. Examples include the perpetrator's age, number of past sexual offenses committed, and preferential choice of victim (Harris & Tough, 2004). Static risk factors have been demonstrated to predict sexual reoffending in individuals with intellectual disability. Lindsay and colleagues (2004) found a clear correlation of static predictors to sexual reoffending, which included poor relationship with mother, sexual abuse in childhood, and offenses involving violence. Variables very closely approaching significance were offenses involving children, tolerance of sexual crimes, lack of previous intimate relationships, and age at first arrest (Lindsay et al., 2004).

Conversely, dynamic risk factors can be subdivided into stable dynamic risk factors and acute dynamic risk factors. Stable dynamic risk factors are enduring but amendable to change over time such as cognitive distortions and sexual arousal (Craig, 2010). Acute dynamic factors are rapidly changing factors that change day-by-day such as substance abuse and negative emotional states (Craig, 2010).

Numerous static and dynamic variables are identified in the literature as important risk factors to consider when looking at sexual offending through a proactive and preventative lens. Factors in the environment that can be beneficial or detrimental in the success of supporting sex offenders require further exploration. In the work on treatment for people with intellectual disability and inappropriate sexual behaviour, Griffiths and colleagues (1989) outline treatment components that can be implemented concurrently or consecutively but do not necessarily need to be included in every treatment model. They include: "social competency skills, sex education, relationship training, responsibility training, coping skills training, and altering deviant behaviour" (Griffiths et al., 1989, pp. 53-54). In addition, a clear description of appropriate

sexual expression must be in place. The implementation of the treatment components is dependent on the presence of deviant sexual arousal and/or results from a thorough assessment of the individual's skill deficiencies. The goal is to "assemble pertinent treatment components into a single program" (Griffiths et al., 1989, p. 131).

Although the treatment components identified are important to increase skills and reduce inappropriate sexual behaviour, gains in treatment will be mitigated by an unsuitable environment that is not set up to accommodate long-term success and prevent re-offenses. The relapse prevention model described by Griffiths and colleagues (1989) identifies what needs to be in place to maintain treatment progress and prevent re-offenses: "Setting realistic expectations, implementing generalization training, establishing coping strategies, incorporating consequence training, identifying and providing community support, offering booster treatment sessions, and prescribing medication" (Griffiths et al., 1989, p. 90). Through this model, service providers can identify the basis of what needs to be in place to effectively support people with intellectual disability and sexual offending behaviour in a community-based, preventative manner, while maintaining a balance of using the least intrusive measures and managing risk to the individual and the community (Griffiths et al., 1989). However, since the time of this model, considerable research in the field has occurred and alternative theories have been developed.

Best practice models supported by empirical evidence for mainstream offender treatment and rehabilitation have led to a shift away from traditional punitive measures towards the application of human services to reduce recidivism. The Risk, Need, Responsivity (RNR) model by Andrews and Bonta (2007) has gained empirical support for reducing offender recidivism and poses three principles for effective offender rehabilitation:

The risk principle states that the intensity of an intervention must match the offender's level of risk. A high-risk offender should not be receiving minimal interventions and supervision

and a low-risk offender should not be receiving intense interventions and supervision. According to this principle, a mismatching of intervention to the level of risk (e.g. a low risk offender receiving intense interventions) can worsen an offender's state and consequently, increase risk (Andrews, Bonta, & Wormith, 2011).

The need principle states that treatment programming must target dynamic risk factors and criminogenic needs most related to offending. There must be a specific focus on lifestyle areas that led to the offending in order for treatment to be effective and to reduce the risk of reoffending (Andrews et al., 2011).

The responsivity principle states that the style and type of interventions or supports must match the offender's personal characteristics such as learning style, cognitive ability, strengths, motivation, and "the individual's personal and interpersonal circumstances" (Wilson & Yates, 2009, p. 158).

The RNR model has been criticized in the literature as being highly risk-based rather than focusing on individual strengths and well-being (Ward & Stewart, 2003). Ward and colleagues (Ward & Gannon, 2006; Ward & Stewart, 2003) propose a Good Lives Model (GLM) as a broad rehabilitative framework and the integration of a self-regulation approach. The GLM is a strength-based approach that focuses on individuals as goal seeking that aim to acquire primary human goods that, if achieved, can increase overall well-being. This model will be discussed in more detail in the following section of this review.

Research Related to Re-offense Variables

For the purpose of illustrating various research avenues, the research has been presented below under preventative risk factors and more imminent risk factors that require proactive and responsive measures of intervention.

Prevention. In a review of self-regulation and relapse prevention, Ward and Hudson (1998) expand on Pithers (1990) adaptation of relapse prevention, which states that the inability to cope with high-risk and stressful situations are two factors that are direct links to offender relapse. Ward and Hudson (1998) take this discussion further by including several phases of self-regulation that can lead to relapse. Stressful life events, such as a major transition or an argument, can trigger specific thoughts, emotions, and intentions that, without the proper coping strategies, can lead to a re-offense (Ward & Hudson, 1998). Therefore, equipping individuals with the skills needed to cope with stressful events to minimize the likelihood of a re-offense is an important preventative measure.

Drug and alcohol use can be applied to risk management as a life choice that presents risk and warrants preventative intervention. In fact, researchers have found that increased use of drugs and alcohol is related to reoffending. In a study by Hanson and Harris (2000) comparing sexual reoffenders and sexual non-reoffenders, they found that the reoffenders were most likely to abuse drugs and/or alcohol, and the amount of substance abuse increased just prior to reoffending.

This finding is also highlighted by Boer, Tough, and Haaven (2004), who identify that having an alcoholic drink at a family gathering is a socially acceptable behaviour, however offenders with intellectual disability tend to have impulsivity problems that can be exacerbated by alcohol. Thus, what is socially acceptable and safe for some people may not be the case for offenders with intellectual disability, and the same can be said about drugs (Boer et al., 2004). This article will be referred to consistently throughout this review as it presents a valuable and comprehensive theoretical framework that has led to the development of an empirically validated risk assessment tool for people with intellectual disability who sexually offend. This tool will be

presented further on in this review. The dynamic risk factors discussed by Boer and colleagues (2004) are accurate predictors of sexual recidivism (Blacker, Beech, Wilcox, & Boer, 2011).

Amount of supervision to limit access to victims has been found to decrease the likelihood of reoffending. As mentioned previously, McGrath and colleagues (2007) report lower recidivism rates in their study in comparison to other studies. They partly attribute this variation to the amount of intense supervision participants in their study received, as 62.1% received 24-hour supervision which limits accessibility to potential victims (McGrath et al., 2007).

Supervision has been frequently cited in the literature as a fundamental dynamic risk factor. Hanson and Harris (2000) conducted a comprehensive study comparing 208 sexual reoffenders to 201 sexual non-reoffenders on a number of variables through interviews and file reviews. They found that individuals who had not reoffended were more cooperative with supervision than the individuals who reoffended. Further, although both groups of individuals attended the same number of treatment programs, the reoffenders were more often disengaged from treatment and supervision and they tended to miss scheduled appointments more than the non-reoffenders. This suggests that amount of and compliance with supervision were related to recidivism in sexual offending, while less supervision and lower compliance with supervision were related to an increase in the risk of reoffending (Hanson & Harris, 2000). This study will be revisited throughout this review, as the numerous variables examined are relevant to various areas of risk management.

Amount of supervision and level of risk have been identified in other studies (Boer et al., 2004). A number of dynamic risk factors have been presented by researchers and argued to be just as related to risk as they are to manageability in institutions or community-based settings (Boer et al., 2004). In other words, an offender's manageability can be improved by ensuring his

dynamic risk factors are under control or ameliorated. Although this list is not exhaustive and level of relevance would depend on the individual offender, a prominent risk factor that is identified by these authors is consistency which encompasses consistency in staff, routine, and supervision (Boer et al., 2004).

Boer and colleagues (2004) present a theoretical framework that considers important aspects for current risk management of sex offenders with intellectual disabilities. Offenders with intellectual disability tend to manipulate and exploit any inconsistencies that may develop amongst supervisory staff. This inconsistency can arise if a staff member treats an offender as if they are a child or their favourite, which creates harmful consequences when other offenders notice this difference in staff treatment. This also creates a disadvantage for other staff members who are then unable to work with the offender effectively. Of most importance is that offenders with intellectual disability become accustomed to a style of supervision; changes in staff approach, staff turnover, or staff caseload need to be avoided however possible in order to minimize circumstances that increase risk (Boer et al., 2004).

Furthermore, consistency in staffing can include the dynamic risk that is presented with the start of new staff working with the offender. The effects of this can be minimized through ensuring new staff have sufficient training prior to working with the offenders, as well as a limited work load with the individuals so that the transition is slow and gradual. This period of new staff may evoke some acting out or testing of boundaries by some offenders (Boer et al., 2004). Although the start of new staff cannot always be avoided, it is important to recognize that when a new staff member begins working, risk does increase, so this should be accounted for and alleviated in every way possible.

Consistency in routine is an important factor to consider in the assessment of risk for offenders with intellectual disability. The predictability of the offender's behaviour is highly

sensitive to environmental consistency and so consistency in routine will help provide staff with better awareness of the individual. In other words, changes to the setting where the offender lives may be upsetting to the individual and consequently, can lead to unstable behaviour that come as a surprise to the staff members. This consistency in routine also includes highly structured environments where the individual can be involved in some form of meaningful activity (Boer et al., 2004).

According to the research by Boer and colleagues (2004), boredom was identified as an issue for all offenders with intellectual disability. Routines in activities and a structured and full day can reduce boredom and prevent the occurrence of high-risk behaviours (Boer et al., 2004). Due to these individuals' living environments, change in routine is sometimes inevitable however it is important to recognize that seemingly minimal changes in scheduling can greatly increase risk. Similarly, a drastic change in routine and structure, such as a relocation, affects all aspects of the offender's environment. As Boer and colleagues (2004) point out, "not all ID offenders cope well with change and the external structure that a familiar place or daily routine brings to such offenders is an important aspect of their sense of self-control and well-being" (p. 280).

Lastly, consistent supervision must be provided through unique monitoring strategies for every offender (Boer et al., 2004). Supervision can be in the form of direct observation of the offender at all times by one or more staff members. This level of supervision can allow for any change in the offender's behaviour to be recognized, including changes in emotional state, behavioural stability, or mental health indicators that can trigger an appropriate intervention to be implemented immediately. Additionally, consistent supervision can allow staff to notice any changes in risk factors as a result of changes in life situations, which will alert the need for additional monitoring. For example, a change in the offender's routine, such as watching a park from afar, can be extremely significant and may reveal new potential to offend. It however can

only be identified through proper staff supervision; Boer and colleagues (2004) provide the following scenario to illustrate this point: "The presence of a new family in an apartment block may result in delays in catching public transit by the offender who has taken an extra 5 min[utes] to watch the new children get on the school bus" (p. 280). This is a suitable example of when offenders try to increase their access to victims, which is another variable that can be alleviated through adequate supervision.

While offenders often try to increase their access to victims, sometimes they encounter potential victims unexpectedly. Depending on the environment, potential victims could be children or women who come to visit another individual in the building or people they encounter during a trip to the community and so staff knowledge of the offender's victim choice and supervision surrounding these situations is crucial (Boer et al., 2004). Not only are consistency in staff, routine, and supervision important in the assessment of risk, but they are also an integral preventative measure for promoting resiliency and a good quality of life.

The idea of resiliency, involving building a life that is not worth losing for the offender, is a concept that has not been widely explored in the literature. There are however, studies on quality of life measures that aim to evaluate fundamental changes in services provided to people with intellectual disabilities, which play a major role in their day-to-day lives (Felce & Perry, 1995). Felce and Perry (1995) propose a quality of life model that encompasses dimensions of physical, material, social, and emotional well-being, along with development and activity. The physical dimension can include health, fitness, and personal safety. The material dimension may include income, possessions, housing quality, and privacy. The social dimension encompasses family, friends, and community involvement through activities, events, acceptance, and support. Emotional well-being includes positive affect, fulfillment, self-esteem, and faith/belief. Finally, the development and activity dimension may include employment, housework, leisure/hobbies,

education, and independence (Felce & Perry, 1995). All of these components that make up quality of life are important enhancements to apply to risk management with offender assessment and treatment. For example, in addition to focusing on sex offender's risk factors, it is important to provide them with opportunities that incorporate the various dimensions of quality of life, such as access to exercise, material possessions, and positive relationships. Furthermore, these elements of the quality of life model are not only important in the area of risk management, but rather are necessary features of quality of life for all people, including offenders.

Dewhurst and Nielsen (1999) discuss a resiliency-based approach to working with sex offenders that they propose should be included in offender treatment as a way for the offender to bounce back from adversity and repair him/herself. Six core resiliencies that apply to sex offenders, as described by Wolin and Wolin (1993) are initiative, ability to develop relationships, morality, creativity and humour, independence, and insight. In addition, Dewhurst and Nielsen (1999) add empathy as a seventh resiliency factor. The authors state that these resiliencies tend to be used in therapy as ways of pointing out how the offender is lacking in these qualities. Rather, an effective resiliency approach should be looking to build up these core resiliencies in the offender by seeking out examples of the offender demonstrating these factors (Dewhurst & Nielsen, 1999).

The resiliency model recognizes an important concept and is an extremely valuable piece to add to sex offender treatment. The GLM which will be revisited in this section, was originally proposed by Ward and Stewart in 2003 and has since been considerably developed. The GLM provides a rehabilitation framework that has been applied specifically to treatment for sex offenders in the general population (Ward, Mann, & Gannon, 2007). It is a positive model that states that sex offenders, like all humans, value certain states of mind, characteristics, and experiences that, if achieved, are likely to increase well-being and functioning. The GLM is

based on the main assumption that "the best way to reduce risk is by helping offenders live more fulfilling lives" (Ward et al., 2007, p. 94). "Primary goods" that all people strive for can include healthy living and functioning, knowledge, excellence in play and work, autonomy, inner peace, community, happiness, creativity, and friendship, including intimate, romantic, and family relationships (Ward et al., 2007, p. 90). This model assumes that, "sexual offending reflects socially unacceptable and often personally frustrating attempts to pursue primary human goods" (Ward et al., 2007, p. 90). Thus, the experiences, relationships, and activities in an offender's life will result in enhanced levels of well-being, rather than actions that are considered morally good. Equally important with having these 'primary human goods' is the means to effectively secure them so that the need to offend to secure basic goods is no longer present (Ward et al., 2007).

The GLM states that the concept of personal identity is important to sex offenders' understanding of what constitutes a good life (Ward et al., 2007). In other words, people's actions and what they do directly influence how they view themselves. Therefore, according to the GLM, therapists need not only equip sex offenders with coping and self-management strategies, but also with opportunities to build a good life, one that bestows a sense of purpose and fulfillment. Providing offenders with the proper skills (e.g. coping skills, social skills, values) as well as desired external conditions (e.g. resources, social supports, opportunities) will reduce the need for offending behaviour as it no longer serves a purpose. However, the notion cannot be ignored that "simply seeking to the increase of the well-being of an offender without regard for his level of risk may result in a happy but dangerous individual" (Ward et al., 2007, pp. 92-93). Thus, the authors briefly touch upon the notion of establishing a functional balance between a fulfilling life and risk management. It is this important piece of instilling a good life that is missing from treatment of sex offenders, specifically from models such as RNR that have been criticized for focusing too heavily on risk management (Ward & Stewart, 2003).

Integrated with the GLM is the self-regulation/pathways model that was touched upon previously (Ward & Hudson, 1998). According to the self-regulation approach, people are goal-oriented and act to achieve a desired state or to avoid an undesired state. There are four pathways that address an individual's goals, whether they are approach goals or avoidant goals, and how these goals are achieved, either actively or passively. The four pathways that people who sexually offend may follow as described previously, are avoidant/passive, avoidant/active, approach/automatic, and approach/explicit.

Work by Haaven and Coleman (2000) incorporates the idea of building a good life with the distinction between the 'old me' and 'new me' in treatment of sex offenders with intellectual disabilities. The 'old me' includes the individual who committed sexual offenses and has beliefs, values, and goals that connect to offending behaviour. The construction of a 'new me' must entail a new set of goals, values, beliefs, and ways of living that reflect a good life for the individual, one where primary goods are achieved and sustained through socially acceptable ways. This 'new me' conceptualization may include friends, family, activities, events, and material possessions (Haaven & Coleman, 2000). Therefore, the construction of a good life based on each individual offender is a crucial aspect that should be included as an interrelated feature of risk management models to reduce risk of reoffending.

A portion of the results from Hanson and Harris (2000) can be applied to the GLM, specifically in regards to social influences and intimacy. They found that the social environment of the non-reoffenders had more positive influences than negative, whereas reoffenders had more negative influences than positive. Similarly, the reoffenders experienced more intimacy problems, such as relationship conflicts and lack of intimate partners, whereas this finding was reversed for the non-reoffenders. Thus, a lack of positive relationships is an important piece of the GLM that has been shown to increase the likelihood of a sexual re-offense.

Lindsay (2005) indirectly emphasizes the GLM, stating that a good life should entail community involvement. Otherwise, a lack of engagement in society can lead to two important consequences: "First, if the individual is not engaged in occupational, leisure, and social activities, they have more time to engage in antisocial or deviant activities. Second, their number of prosocial influences is correspondingly reduced" (Lindsay, 2005, p. 435).

Despite the strong emphasis placed on the importance of quality of life and resiliency in the literature, these concepts are not commonly applied to sex offenders with intellectual disability as a measure to prevent reoffending. While components of risk management are important for reducing recidivism, equally important is that quality of life and a 'good life' are provided to the offender, which may include friends, family, intimacy, activities, community inclusion, and material possessions. These are essential features of life that are sought out by all people; these features lead to a fulfilling life for the individual, and consequently, will work to minimize the risk of sexual offending.

Proactive and responsive.

There has been strong evidence in the literature that focuses on antisocial attitude and its relation to antisocial behaviour, including sex offenses. Quinsey, Coleman, Jones, and Altrows (1997) compared mentally disordered male offenders in hospital who had eloped or reoffended with male offenders who had done neither. Antisocial attitude, which includes lack of remorse and empathy, was the best predictor of violent reoffending. This finding emphasizes the importance of providing appropriate intervention and monitoring when an offender is displaying these features as it has such a strong link to a violent re-offense. In addition, Quinsey and colleagues (1997) found that poor compliance with supervision, escape attempts, and poor positive coping skills were related to eloping but not reoffending. However, it could be the case

that eloping is one more stepping stone closer to reoffending and so these variables can be considered a more distant factor in reoffending.

The study by Quinsey and colleagues (1997) focused on offenders in general rather than specifically sex offenders. Hanson and Harris (2000) used the same procedure as in the study by Quinsey and colleagues (1997) but included a sample of sex offenders. They found that, in comparison to non-reoffenders, individuals who had reoffended had, "poor social supports, attitudes tolerant of sexual assault, antisocial lifestyles, poor self-management strategies, and difficulties cooperating with supervision" (p. 6).

Followed up over a 12-month period, a study of 52 sex offenders with intellectual disability where some had reoffended, found that antisocial attitude, allowances made by staff, staff complacency, and poor response to treatment were significantly correlated with evidence of re-offending. Low treatment motivation, deterioration in family attitudes, allowances made by staff, and staff complacency were significantly correlated with suspicion of reoffending (Lindsay, Elliot, & Astell, 2004). Suspicion of reoffending refers to reliable reports of documented incidents of high-risk behaviour making it highly likely that the individual reoffended. This was included in the study as a safeguard against un-reported reoffending which is a common problem in prediction studies. Lindsay and colleagues (2004) make note that antisocial attitude, poor motivation, and poor compliance with treatment consistently emerge as predictors of reoffending. Part of these findings are also supported by Boer and colleagues (2004) who state that compliance with supervision and treatment, including attendance and participation, are significant risk factors for reoffending and that treatment completion and supervision compliance are common elements associated with low recidivism.

Supporting these findings is research conducted by Lindsay and Beail in 2004. They examined the predictive value of a variety of known risk assessment variables in a sample of 52

sex offenders with intellectual disability, 18 of whom reoffended following treatment. A number of static and dynamic variables were found to predict sexual reoffending, including antisocial attitude, low self-esteem, attitudes tolerant of sexual crimes, low treatment motivation, deteriorating treatment compliance, and staff complacency. The most significant predictors of reoffending however were the dynamic variables: antisocial attitude, denial of crime, allowances made by staff, and deteriorating compliance. Even further, out of 50 variables that were examined, the most significant dynamic variables with the strongest predictive power were allowances made by staff and antisocial attitude (Lindsay & Beail, 2004).

The findings of this study strongly tie into the risk factors discussed by Boer and colleagues (2004). Changes in attitude or behaviour towards supervision or treatment can occur by an offender stating they do not want to attend treatment or monitor their risk factors any longer. This is problematic as it indicates that an offender either has encountered a temptation that they want to pursue or that they have already committed a sexual offense that they are trying to hide. This speaks to the importance of having open communication and a trusting relationship with the staff support team so that the offender can feel comfortable reporting a lapse in behaviour. Developing rapport and comfortable communication about these issues in order to reduce risk of reoffending will be revisited later in this review.

Additionally, staff complacency as noted by Lindsay and Beail (2004) is a significant predictor of recidivism in sex offenders with intellectual disability, and has been consistently noted in the research (Boer et al., 2004; Craig, Browne, & Stringer, 2003; Lindsay et al., 2004).

An offender resuming old patterns or fantasies and engaging in inappropriate or antisocial behaviour can be clear warning signs that the individual is not managing well and is approaching a re-offense. In a study by Quinsey, Book, and Skilling (2004), they followed a sample of 58 men with intellectual disability over a 16-month period after being transferred to community

settings. They found that ratings of inappropriate and anti-social behaviour were the best predictors of subsequent inappropriate violent or sexual behaviour (Quinsey et al., 2004).

Proulx, Perreault, and Ouimet (1999) studied 44 nondisabled males who had committed at least one sexual offense against a prepubescent child. They found that the offenders engaged in frequent deviant sexual fantasizing and masturbation to these fantasies prior to their sexual offense. Deviant sexual fantasizing served to be an immediate precursor to reoffending (Proulx et al., 1999). This finding points to the importance of individuals working with the offender being fully aware of their preferential victims, grooming behaviour, and their risk factors (Boer et al., 2004). The offenders themselves need to have knowledge of their maladaptive thoughts, risk factors, and risk management plan, which is typically gained through treatment. An offender who clearly knows his own risk factors through open and ongoing discussion amongst the people who work with him is more likely to monitor these factors regularly and effectively. Consequently, the offender is less likely to lie about high-risk situations that they encounter when this knowledge is frequently reviewed with support staff (Boer et al., 2004).

Parallel to the findings by Proulx and colleagues (1999) is the imminent risk associated with an increase in an offender's sexual preoccupation. Boer and colleagues (2004) state that behaviours such as accessing pornography and pictures of children, and watching television with preferred victims are extremely high risk and indicative of sexual reoffending. These behaviours require an immediate response by the supporting staff in order to interrupt an extremely high-risk pattern of behaviour.

A lack of coping strategies can require a more proactive or responsive level of intervention when the offender has the coping strategies, but decides not to use them. This risk factor also includes when the offender stops recognizing risky situations or fails to use familiar problem solving strategies. An offender may begin to 'boundary test' by going to areas he knows

has lots of potential victims or going into stores that sell pornography. This sudden change is indicative of an impulsive decision not to use coping strategies and displays a change in his ability to make good choices (Boer et al., 2004). This risk is also present if there is a major change in the offender's life, including a change in a significant relationship. If the offender's ability to cope is altered or if he is in a negative emotional state which makes using coping strategies much more difficult, then this factor is linked to serious risk of offending. However, if the change is considered positive the offender's ability to cope may be significantly better.

Upon examining several of the dynamic variables that have been discussed, it is evident that they are characteristic of behaviours that can be influenced by the external setting, or influenced by the environment.

Influence of the Environment

In addition to considering the research identifying the dynamic variables that can lead to reoffending, it is important to consider the environments in which these offenders typically live. People with intellectual disabilities who have sexually offended may live in systems such as group homes and treatment homes rather than independently. Because of this, there is the potential to influence these dynamic variables that have been shown to predict reoffending. Environmental variables are of even greater importance in assessing and managing risk in individuals with intellectual disability. However, there is a gap in the literature on how these environmental systems can intervene and impact dynamic variables.

Boer and colleagues (2004) recognized the gap in the literature by acknowledging the greater dependence of people with intellectual disabilities on external structures and supports and how this relates to reoffending. The researchers sought to explore a broader framework that includes dynamic environmental variables along with the commonly referenced dynamic client variables (e.g. antisocial attitude, substance use) to assess risk more accurately and, therefore,

develop better risk management plans to prevent reoffending. This led to the development of the instrument for Assessment of Risk and Manageability of Intellectually Disabled Individuals who Offend Sexually (ARMIDILO-S; Boer, McVilly, & Lambrick, 2007). This assessment expands upon environmental variables to include a wide range of issues such as, "staff attitudes towards individuals with intellectual disability, communication amongst supervisory staff, client knowledge by staff, supervision consistency, environmental consistency, victim availability and access, availability of intoxicants, social support changes, and use of structured daily activity plans" (Boer et al., 2007, p. 2). The development of the ARMIDILO-S is a much needed instrument that recognizes the lack of focus on environmental variables that influence reoffending. In a recent study that assessed the predictive validity of four risk assessment instruments (RRASOR[1], SVR-20[2], RM2000-V[3], ARMIDILO-S) on a sample of 44 mainstream sex offenders and 44 sex offenders with intellectual disability, the ARMIDILO-S was the single best predictor for sexual re-offense among people with intellectual disabilities (Blacker et al., 2011). However, an important consideration of this study is that the environmental subscales were not included because the information required to complete this section was not documented in files.

Until recently, the ARMIDILO-S lacked empirical validation (Blacker et al., 2011), however a new study by Lofthouse and colleagues (2013) showed the predictive validity of this risk assessment tool for people with intellectual disability and sexual offense histories. In a sample of 64 males with intellectual disability and sexual offending behaviour, the researchers

[1]The Rapid Risk Assessment for Sex Offense Recidivism (RRASOR) consists of 4 items used to predict sexual
[2]The Sexual Violence Risk (SVR-20) assessment contains 20 items, which include stable and acute dynamic risk factors to predict sexual violence recidivism (Blacker et al., 2011).
[3]The Risk Matrix (RM2000) is a two-dimensional risk assessment consisting of two scales: one measuring risk of sexual recidivism and another measuring risk of non-sexual violence. It has shown to significantly predict violent recidivism in sexual and sexual/violent offenders (Blacker et al., 2011).

found that dynamic risk factors can accurately predict sexual recidivism, and the ARMIDILO-S yielded the best prediction of sexual recidivism in comparison to two actuarial risk assessment tools (e.g. STATIC-99[4], VRAG[5]). Hence, dynamic and environmental variables are extremely relevant for people with intellectual disability due to their high reliance on external structures and supports in the environment. Lindsay and colleagues (2004) have also reported that dynamic variables are better predictors of sexual reoffending than static variables, making the ARMIDILO-S an important and promising assessment for sexual reoffending in people with intellectual disability (Lofthouse et al., 2013).

In addition to the emergent alternative theories that have been presented in the field, society has taken a drastic shift towards a culture of rights which can be seen through various projects and policies such as the United Nations Convention on the Rights of Persons with Disabilities (United Nations, 2006), Americans with Disabilities Act (ADA, 1990), and the Three Rs Project (Owen et al., 2003).

Context of Risk in a Culture of Rights

Supporting individuals in community-based settings who have intellectual disability and deviant sexual behaviour presents significant challenges in terms of upholding human rights while at the same time, appropriately managing risk to the individual and the community. Previously, individuals with intellectual disability were not seen as persons and therefore were not treated with the same human rights as people without disabilities. They frequently experienced victimization and had their rights infringed upon more so than people without disabilities (Owen et al., 2003). Currently, there is a cultural shift towards more rights-based treatment of people with disabilities which has been magnified based on the normalization

[4] STATIC-99 is a static risk assessment for sexual offending (Lofthouse et al., 2013).
[5] Violence Risk Appraisal Guide (VRAG) is a static risk assessment for violence (Lofthouse et al., 2013).

movement. However, people with disabilities in supported living situations (staffed by community agencies) still experience limitations in respect to choice and rights that are often taken for granted by non-disabled individuals. Often, their rights are denied because service providers believe they do not have the skills or abilities to make choices or participate in activities (Owen et al., 2003). This has led to a strong movement within agencies towards a Rights Agenda (Griffiths, Owen, & Watson, 2012).

The rights that are most commonly enshrined in doctrine for people with intellectual disabilities are identified in the UN Convention on the Rights of Persons with Disabilities (United Nations, 2006) and have been ratified by each province in Canada. As such, the guiding principles are to be encouraged throughout Ontario in all government direct or indirect programs. These include the right to education, health, independent living, work and employment, community inclusion, relationships and family, access to the justice system, habilitation and rehabilitation, freedom from abuse, and privacy (Griffiths et al., 2012). Other areas in the literature that focus on the rights of people with intellectual disability include the right to community living (Owen & MacKinnon, 2012), the right to consent to treatment (Watson, Richards, Hayes, Lecomte, & Taua, 2012), and rights within the justice system (Hamelin, Marinos, Robinson, & Griffiths, 2012).

The research on rights and intellectual disability also highlights the right of choice and decision-making within service delivery which are reasonable and expected rights these individuals are entitled to as people (Griffiths et al., 2003). This cultural transformation has introduced a new dynamic of interacting with high-risk behaviours. Does someone with Prader-Willi syndrome have the right to choose to consume large amounts of food and consequently, complicate their health? Does an individual with poor street safety skills have the right to choose to go into the community on their own and get injured? Does a person with intellectual disability

and sexual offense histories have the right to choose to go to areas with high victim access and increase their risk of offending against a child? Community care providers must respect the rights of the people whom they support while also being responsible for the safety of those individuals who are considered vulnerable and who display high-risk behaviours (Owen et al., 2003). Research on Prader-Willi syndrome highlights this challenge well.

Support workers in a group home for people with Prader-Willi syndrome faced the difficulty of managing two conflicting duties outlined in their agency policy: protecting the individuals by providing their duty of care and respecting individual autonomy (Hawkins, Redley, & Holland, 2011). People with Prader-Willi syndrome have severe overeating behaviour that is associated with the syndrome. If left unmanaged, many individuals with this disorder would experience life-threatening obesity and other serious health implications. Through observations, semi-structured interviews, and file reviews, this study examined how staff members who support these individuals balance the maintenance of their safety while also promoting their independence. Within the agency, risk was identified clearly at the level of the organization and from there, standardized risk management practices were created. Support workers aimed to reconcile the conflicting duties by adhering to risk management protocols while at the same time, promoting independence in other possible areas. Some support workers deviated from the standardized risk management practices and incorporated independence into the resident's care plans, which was problematic from the risk management perspective (Hawkins et al., 2011). This study highlights the tension that exists between duty of care and autonomy but identifies a valuable strategy of promoting independence where it is feasible, without jeopardizing safety.

The study by Hawkins and colleagues (2011) illustrates key considerations when supporting individuals who present with risk to themselves. This study presents a parallel

discourse to the treatment and management of persons with intellectual disability who sexually offend in the community. However, the issue of duty of care and autonomy is exacerbated with offenders who present with high-risk behaviours as these behaviours not only affect themselves, but also people in the community. This notion makes it even more crucial that this balancing act be addressed, as sex offending behaviours involve potential harm to the individual and others. In addition to personal autonomy, community inclusion, and choice, individuals with intellectual disability "have the right to realistic and supportive risk management, including accountability" (R. Wilson, personal communication, July 31, 2013).

All human beings are granted rights and this includes sex offenders. Although the bulk of the literature on sex offenders pertains to assessment, treatment, and risk factors associated with reducing the rate of recidivism, very little research discusses the rights of these individuals. Upholding the rights of people who sexually offend may prove to be difficult when the government restricts their freedoms. Additionally, members of the community tend to believe that these individuals forfeit their human rights due to the crimes they have committed. Ward, Gannon, and Birgden (2007) apply a model of human rights to the assessment and treatment of sex offenders in the general population, and identify that the latter logic is problematic both ethically and practically in ensuring effective rehabilitation of sex offenders. They argue that "there are ethical, pragmatic, and therapeutic reasons for respecting offenders' human rights," while still acknowledging that ensuring public safety and respecting the rights of past and potential victims is the number one obligation of clinicians or service providers (Ward et al., 2007, p. 204). Ward and colleagues (2007) stress that, "offenders have entitlements of their own that ought to be actively considered. However, sex offenders also have obligations not to harm others" (p. 204). Birgden and Cucolo (2011) also support this view, as they argue that

practitioners need to emphasize community inclusion through adequate support rather than social exclusion through restrictions. They point to the need to achieve a community-offender balance.

Similarly, Ward and Salmon (2011) discuss ethical issues associated with risk management and community protection. Public and correctional policies emphasize community protection and work to achieve this by imposing harsh restrictions on sex offenders as a way to keep them quarantined from the rest of the community. However, such harsh restrictions force the offenders to live with minimal dignity and have diminished well-being making it difficult to establish supportive relationships in the community and move towards a healthy and rehabilitative state. Therefore, these authors also stress that the goal of ethical treatment, "should be to ensure that sex offenders and nonoffenders have the essential capabilities to live better lives, and this necessarily involves paying attention to offenders' needs as well as containing and reducing their risk" (Ward & Salmon, 2011, p. 401).

Furthermore, imposing harsh restrictions without regard for offender rights and welfare is also evident in treatment-as-punishment as ordered by the courts. Within these forms of treatment programs, the offender's rights are curtailed and there is no consideration of their welfare. Treatment decisions are usually made without being in the best interest of the client. With these types of programs, the primary purpose of treatment is the protection of the community rather than to provide ethical rehabilitation to the individual (Glaser, 2003). Birgden and Cucolo (2011) address this issue as well through their discussion surrounding the immorality in providing treatment-as-management. They argue that treatment-as-management is ineffective and unethical as offenders often experience legal pressures to engage in treatment, which can be implemented through civil commitment. This is forced treatment that may not provide quality treatment with qualified professionals and it offers minimal therapeutic benefits.

Taking into consideration the aforementioned research, it appears as though a sufficient method of dealing with sex offenders is to have a balance of managing risk to the community while also granting individuals their rights, including the right to effective treatment. There is a large discrepancy in the literature when looking to combine human rights for sex offenders with intellectual disability, as the majority of research focuses on human rights in intellectual disability or human rights for sex offenders without disabilities. As previously discussed, people with intellectual disability and sexual offending behaviours often live in systems run by organizations that have adopted prominent rights-based policies for the individuals they support. As such, a balance must be maintained that ensures offenders are granted their rights, coupled with protecting the rights of the community to not be inflicted harm. This further illustrates the debate surrounding duty of care versus autonomy and emphasizes the need for a carefully constructed plan that encompasses a fair balance of risk management and rights.

Summary

In summary, throughout history people with intellectual disability had few rights as they were not seen as people. Over time, people with disabilities were segregated and invisible from the rest of society. Treatments for high-risk and challenging behaviour were restrictive and intrusive rather than therapeutic and rehabilitative. Through research on offender typology and static and dynamic risk factors associated with sexually offending behaviour, effective assessments and treatments have been made available. A treatment model needs to take into account the nature of the offense, it needs to match the type of offender and their profile, and it must provide individualized treatment that builds up the offender's quality of life and the chance of obtaining a good life. Risk management must be incorporated into a model of treatment as well, as there is no guarantee that the skills an offender learns in a therapeutic treatment setting will be generalized across settings and situations in real life. All people are granted human

rights, and there has been a recent shift in the emphasis of rights in social service agencies that provide support to people with disabilities and sexual offending behaviour. Of the utmost importance is that while providing support to people with intellectual disability and inappropriate sexual behaviour, there is a reasonable balance between upholding rights and managing risk to the individual and the community. The role of the environment (Boer et al., 2004; 2007; Lofthouse et al., 2013) may impact offending among people with intellectual disability who sexually offend, but the research is still very limited and underdeveloped. Therefore, this research will examine three types of settings and aim to answer the overarching question, "How are people with intellectual disability who sexually offend being supported in community-based settings?" This umbrella question will be explored through the following questions based on staff perceptions:

1. What are the attitudes of staff who provide support to people with intellectual disability who sexually offend?
2. What factors do staff members describe as impacting the support provided to people with intellectual disability who sexually offend?
3. What structural components of the living environment do staff members describe in terms of supporting offenders?
4. What role does quality of life and living the 'good life' play in relation to providing support for offenders?
5. What training have staff received to work in the field, as well as to work with people with intellectual disability and sexual offending behaviour?
6. What are staff members' perspectives on the treatment provided for people with intellectual disability who sexually offend?

7. Do staff members employ or have an understanding of risk assessment and risk management?

Method

Research Design

An approach based in grounded theory was used to identify characteristics, factors, and responses from participants as a way to link them together in an integrated theory. In grounded theory, theoretical insight is generated through working iteratively with the data in order to illustrate emerging concepts and linkages that are at a constant interplay with the data, while pursuing integration and synthesis (Richards & Morse, 2013). Upon reviewing various research methods, grounded theory was chosen to provide new theoretical findings that have been grounded in the responses from these participants. In addition, this research approach allows for the data to guide the results, leaving opportunities open for unpredictable changes and the ability to test and refine the original theory as the research is conducted (Willis, 2007).

Grounded theory is often focused on a process or an action that has phases which occur over time (Creswell, 2013). In this study, the process was, through the unique knowledge of front line staff, exploring how individuals with intellectual disability and high-risk sexual behaviour are being supported in community-based settings.

Currently, the Good Lives Model (Ward & Gannon, 2006; Ward et al., 2007), the quality of life model (Felce & Perry, 1995), and variables associated with risk management are overlapping models that are supported in the literature. Through a thorough review of the literature, this design aimed to apply these models by using features of risk management and components of quality of life and GLM as the basis of this research. The interview questions were derived from the combination of these three theoretical models, in addition to some questions added by the researcher. The following figure shows a visual depiction of this design.

Figure 1. A depiction of the research design using three models and the umbrella research question.

Participants and Setting

Participants (n=9) were selected through non-random purposeful sampling and were recruited from two social service agencies in Ontario. These participants were six male and three female staff members who provide direct support to people with intellectual disability and sexual offending behaviour. Participants were approximately 25 to 40 years of age and had worked within their agencies for 3 to 13 years and at their respective settings for 2 to 13 years. The participants had college or university level education in developmental service work, social service work, early childhood education, personal support work, and other related social service disciplines. Furthermore, all participants know and understand the offenders they support very well which in part, comes from years worked and through comprehensive, objective reviews of their case files. Thus, these participants were qualified to answer the questions and provide detailed descriptions of phenomena that are not widely known in the field. All participants in the study reported on why they chose their current job. The participants stated that they chose their job because it is challenging, they get enjoyment out of seeing improvements in people's lives, they have a passion for working with this population, and they wanted to work in the field ever since they were exposed to people with disabilities. Providing more specific participant demographics compared across settings would have added an interesting component to the analysis, however reporting this information would have breached the confidentiality that was assured to the participants.

Participants supported people with intellectual disability who sexually offend in four different locations: a treatment residential setting, a transitional residential setting, and two residential settings. A treatment residential setting is a highly structured, secured group home environment that only supports sex offenders with intellectual disability, with strict emphasis on behavioural and risk management protocols. Individuals in this setting receive weekly treatment

with a therapist. A transitional residential setting is a minimally structured, unsecured group home environment with moderate emphasis on behavioural and risk management protocols, to which offenders transition after completing treatment. This environment supports both offenders and non-offenders with intellectual disability, while receiving weekly behavioural supports. Residential settings are group homes that either support only offenders, or offenders and non-offenders, in a shared, unsecured, suburban setting; the emphasis in these settings is not on behavioural and risk management protocols. Offenders in these locations may or may not be receiving weekly therapy sessions.

Recruitment and Consent

Participants were invited to participate in the study through a two-step process of recruitment. First, the researcher organized a time to attend a staff meeting at each of the locations where the purpose of the study was described as well as the role of the participants, including potential benefits and risks if they chose to volunteer in the study. Subsequently, several recruitment flyers were left at the staff meeting for the staff to review and post in their office at their place of work. The researcher recruited from two agencies, one where the researcher had affiliations and one where the researcher had no affiliations. Therefore, two separate recruitment flyers were used, which can be viewed in Appendices A and B.

If participants expressed interest in volunteering for the study, those from the agency where the researcher was affiliated set up a time to be interviewed by two interviewers who were unaffiliated with the agency and were given the option to be interviewed at work or off site. Participants from the agency with which the researcher was not affiliated set up a time to be interviewed with the researcher at work or off site.

Two identical consent forms were signed prior to the start of the interview for each participant. One consent form was given to the participant to keep while the other was taken by

the interviewers to retain for research records. Similar to the recruitment ads, different consents were used for participants in each agency (refer to Appendices C and D). Participants were asked to refrain from mentioning the names of any individual they supported throughout the interview. They were told that if they mentioned a name by accident, it would not be included in the interview transcripts. At the end of each interview, participants were provided with a $10 gift card to Tim Horton's to thank them for their participation.

Design and Procedure

Interviews. A semi-structured interview approach with open ended questions was used as this allowed respondents to express themselves in their own words, avoid format effects, and avoid response bias associated with number and type of options, as well as through suggested answers (Foddy, 1993). The use of open ended questions also allowed for a much richer source of data since the participants had the opportunity to elaborate on their responses. In writing the interview questions, the researcher aimed to ensure that the questions were easy to interpret, short in length, and basic in terms of vocabulary and grammar so that they would be easily understood by all participants and thus, minimize question threat (Foddy, 1993). Participants were asked about their clinical experience, professional opinion, and the structure and organization of their work program. The interview questions used in this research are displayed in Appendix E.

There were five interview questions that were designed to be practical scenario questions. The purpose of the practical scenario questions was to encourage the participants to use their knowledge, experience, and opinions in an applied manner, and to measure their adherence to risk management. Also, this gave the opportunity for the researcher to observe how the data connect or relate to the responses in the practical scenarios. Furthermore, it was extremely beneficial and interesting to see if the themes in participant responses in the main data set were consistent in the practical scenarios. These 'what would you do if…' type of questions also

provided a magnified view of the similarities and differences across settings in a way that solidified and pulled together all the themes in the main corpus of data.

Interviews were conducted in three types of settings: a treatment setting, a transitional setting, and residential settings. These were conducted in a private room or area of the home at a scheduled time decided by the interviewee and interviewers, and lasted between 45 minutes and 2 hours in length. The researcher was affiliated with one of the agencies so two individuals who were unaffiliated with the agency were trained by the researcher to conduct the interviews within two of the settings. Marshall and Rossman (2011) outlined the benefits of conducting research in one's setting of affiliation, stating that, "closeness to the people and the phenomenon through intense interactions provides subjective understandings that can greatly increase the quality of qualitative data" (p. 101). Although other interviewers conducted the interviews, it was easy to develop indirect rapport because the participants were aware of the researchers connection. In addition, it would likely be easier to establish indirect rapport with participants through the interviewers so the interconnectedness between the researcher and the participants could contribute to a mutual understanding that can lead to more accurate interpretations. Therefore, although there were risks associated with conducting research in the researcher's affiliated setting, there were many positive aspects that could greatly increase the quality of the research (Marshall & Rossman, 2011).

One of the interviewers led the interview, while the other took notes with the presence of an audio recorder. The participants provided their consent to have their interview audio-recorded. The interviews were transcribed verbatim and the participants were assured that their audio recordings would be deleted immediately after transcription. By having two interviewers unknown to the agency and participants, the risk of response bias and of the participants

answering in socially desirable ways was minimized. This also helped to assure participant confidentiality since identifying information was not recorded.

Data Collection

Data collection encompassed a "zigzag process" (Creswell, 2013, p. 86) which consisted of going back and forth between participant data, gathering new interviews, and then returning to the original theory to fill in the gaps and elaborate on its components. Data were originally collected from participants in one agency and once these data were reviewed, further data were collected from a second agency with additional participants.

The primary form of data collection in grounded theory research is interviewing (Creswell, 2013). The purpose of the interviews was to gather detailed and descriptive information on the structural set-up and the day-to-day operations of each setting. In addition, participant experiences and professional opinion were collected in order to obtain data-driven results to try to generate theory behind supporting people with intellectual disability and inappropriate sexual behaviour in three unique environments. Memoing, as described by Creswell (2013) is an important characteristic of grounded theory research that was incorporated into this study. As data were collected and analyzed, ideas, themes, and emerging research questions were written down to formulate the process of developing a plan for supporting high-risk offenders, as well as sketching out the flow of the connections between the literature and emerging themes. Through a constant comparative analysis, information from data collection was compared to emerging categories which initialized the main data analysis process.

Data Analysis

Typically with a grounded theory approach, a grounded theory analysis is used to analyze data. However, the researcher chose to use thematic analysis as described by Braun and Clarke (2006). This form of analysis is used within many major analytic research approaches such as

grounded theory but it is in fact its own method. Grounded theory analysis uses different manifestations from within the broad theoretical framework of thematic analysis. Different coding processes are used for grounded theory analysis, where with the open coding process, codes are assigned for each line of data. This process was not feasible for this research due to the length of the interviews. Thus, thematic analysis was used as it allows for flexibility in analysis, which leads to a rich and detailed account of data. In choosing how data will be organized and analyzed, Braun and Clarke (2006) define the data corpus as all the data collected and data sets as all the data from the corpus that are being used for a certain analysis. In this study, the researcher looked at the data corpus which includes all the interview transcripts from each setting, to create data sets that will be used for a particular analysis. In this case, the data sets became the seven major research questions that were explored for themes.

During analysis, the interview questions were organized under the seven main research questions. For example, the research question, "What are the attitudes of staff who provide support to people with intellectual disability who sexually offend?" included interview questions four to 12. Refer to Appendix F for the entire organization of interview questions that were analyzed under each main research question. The practical scenario questions were not analyzed under a main research question; rather they were analyzed on their own as they encompassed various facets of each research question.

Thematic analysis. As described by Braun and Clarke (2006), "thematic analysis is a method for identifying, analysing and reporting patterns (themes) within data. It minimally organizes and describes your data set in (rich) detail" (p. 79). This form of analysis is especially beneficial when investigating a topic area that has limited research available, or when participants' knowledge and opinions on the topic are unknown (Braun & Clarke, 2006). The data were analyzed at a latent level of analysis, where it was examined beyond the surface level

and instead, analyzed through in-depth interpretation. Underlying ideas, assumptions, conceptualizations, and ideologies were identified and serve to shape the data through interpretative work (Braun & Clarke, 2006).

A rich description of the data set was provided through a cross case analysis to identify themes inductively and deductively. The data were looked at deductively by answering the research questions and being driven by the researcher's theoretical interests and preconceptions, as the theoretical basis for the research cannot be ignored. Conversely, the data were examined inductively based on new themes which were not driven by the researcher's theoretical interest in the topic area. This is a form of data-driven thematic analysis.

In relation to the researcher's theoretical interests, the experiences of the researcher produced a specific lens that can partly inform the analysis. It is important to acknowledge one's own theoretical positions and values that are brought to the analysis (Braun & Clarke, 2006). Specifically, the researcher had experience working directly with people with disabilities within residential settings and in a treatment location for people with intellectual disability who sexually offend. The researcher's education included training in Psychology and Applied Behaviour Analysis.

This research followed the qualitative analysis guidelines outlined by Braun and Clarke (2006) but were adapted to fit the needs of this analysis:

1. Familiarizing and reviewing the data – During this phase, the interviews were transcribed and then read over in full. The data from the interviews were put into a chart which was organized by question and participant across settings in order to clean up the data and make it easier to work with. Ideas, considerations, and emerging themes were noted during this initial read through.

2. Generating initial codes – Codes for each interview question were generated, along with codes that described themes within each question. For example, the interview question, 'what factors make this home successful in supporting sex offenders' was coded as, 'successful factors.' One subtheme within this code from participant responses included consistency, and so this subtheme was coded as 'consistency.'
3. Looking for themes – Codes were organized into themes, where the data relevant to each theme were collated respectively. For example, the code 'activities,' included subthemes such as 'festivals,' 'event shows,' and 'sports.' These subthemes were reorganized under the respective codes of, 'community' and 'consistent' under the main 'activities' theme.
4. Reviewing themes – Themes were reviewed to determine if they matched their respective data. In other words, the data within each code were reviewed to ensure they were consistent with the assigned code name, and did not require additional or different coding.
5. Defining and naming themes – Clear definitions and names for each theme were created after an ongoing analysis to refine the details of each theme.
6. Reorganization of codes and themes – The codes and themes under each interview question were organized into the seven main research questions and within that question, the themes were analyzed as a hierarchy according to the nature of the setting, the main themes that emerged from the question, and any subthemes that may have evolved. For example, the interview question "what factors make this home successful in supporting sex offenders" and all its themes and subthemes were organized under the main research question, "what factors do staff members

describe as impacting the support provided to people with intellectual disability who sexually offend?"

After the aforementioned initial analysis was completed, a secondary analysis was conducted based on the results of an inductive analysis of the data. The main inductive theme that emerged was related to rights and risks. In this secondary analysis, references to rights and risks in participant responses were compared across each setting. The following steps will illustrate how this analysis was conducted:

1. Generating initial codes – Codes for each setting were created. These included 'treatment,' 'transitional,' and 'residential.' Subsequently, codes for 'rights' and 'risks' were generated within each setting.
2. Defining themes to be identified – The themes 'rights' and 'risks' were defined in order to have a clear direction of what references to code for the next step in the analysis. The definitions for these themes are presented in the results section of this study.
3. Identifying references to themes – Each interview was read through, looking for references to the themes of 'rights' and 'risks' based on the definitions that were created in the previous step of the analysis. Once a piece of data in the interviews was deemed fitting, it was coded under the respective setting and under the respective theme (e.g. rights or risks).
4. Reviewing themes – Themes were reviewed to determine if they matched their respective data. In other words, the references in participant responses were reviewed to determine if they in fact matched the definition for rights or risks.

5. Quantifying references to themes – Upon completion of organizing the data into the appropriate themes, the number of references for each theme of rights and risks across each setting were identified and reported.

Results

In the results presented below, the findings from participant responses to the interview questions will be reported under each of the seven main research questions.

Staff Attitudes in Supporting Offenders

In this section, the following dimensions will be covered based on participant responses: staff members' opinion on the offenders they support, their beliefs on whether sex offenders have the ability to improve or change, their beliefs on whether sex offenders deserve a second chance, whether people with intellectual disability can be responsible for their own behaviour, and whether sex offenders with intellectual disability can have mutual, healthy, sexual relationships.

Opinion of offenders receiving support. Nine participants stated that they like the offenders they support. Some similarities and differences were seen among settings surrounding why the participants like the offenders. For instance, the participants in the transitional and residential settings stated that their liking of the offenders they support comes from years of knowing and working with them and they have very likable personalities. On the other hand, the participants in the treatment setting stated that they like the offenders they support in terms of a professional staff/client relationship, they have mutual respect, and they are nonjudgmental of them as people. One participant from the treatment setting illustrated the latter well:

> *Yeah, I like them…I like them in the sense that they are, I'm not looking at their offending, I'm looking at their, as an individual, as a person…When you deal with them you find that they are just humans, they are just like you and I but they have this issues (sic), and I don't hold them to their issue, no.*

A final difference from participant responses to this question was from the transitional setting where one participant expressed empathy for the offenders and the situations they are in, reporting that, "what happened to them could happen to anybody."

Offenders' ability to improve/change. All participants stated that the offenders they support can improve or change, however there were different interpretations across the settings of what it means to improve or change for sex offenders with intellectual disability. Additionally, although all participants reported that change is possible, this was contingent on several variables that differed across participant responses in each setting. However, all participants believed that the offenders must be motivated to want to improve and change.

Three out of four of the participants in the treatment setting stated that the offenders they support cannot truly change; who they are is inherent but they can have improvement in their lives. On the other hand, one participant believed that the offenders can improve and consequently, change. In this sense, improvement *is* change. In the former statement, participants were referring to true deviancy such as pedophilia where the offender's sexual orientation cannot be changed, but managed. One participant from the treatment setting outlined this assertion: "I think they can change, are we here to cure? No no, once a sex offender always a sex offender so there is no change in that, can the individual learn to manage? Yes." This is similar to a response in the transitional setting where one participant specified that if the offender has an organic or inherent impairment, he cannot change because the brain is very "complex" and there is nothing that can be done to "correct it." The participant illustrated this by stating, "if they are born that way, they deserve to change, but they can't change." This theme displays an assumption that biology drives behaviour and since biology cannot be changed, neither can an individual's behaviour. The inability to change true deviancy was also briefly mentioned by one

participant in the residential setting. Although this theme was seen across all settings, not every participant in each setting referred to true deviancy in this question.

Similarities were found in the treatment and transitional settings in terms of what is required for change to occur. According to participants from these two settings, change is dependent on the amount of programming that staff members put in place for them which can include activities that keep them busy and "out of trouble." According to the participants from the treatment and transitional settings, these responses came from the fact that they had witnessed offenders' success in treatment and in the community.

There were some responses that were unique to participants in specific settings. For instance, in the treatment setting one participant stressed the difficulty associated with long-term change, identifying that once an offender is in an environment where he thinks he can get away with an offense, he is likely to engage in an offense. This ability to manage was a prominent theme unique to participants in the treatment setting and was exemplified by those participants who believed improvement equates with change. All participants in this setting had seen offenders finish treatment and live successfully in the community, which is attributable to the support they received and their ability to manage their behaviours.

Another response unique to the treatment setting was by one participant who identified the barriers associated with the ability for offenders to improve or change. According to this participant, to accomplish long-lasting change offenders require intense and constant treatment for a long period of time. However, the funding for staffing and therapists is not available to accommodate this level of treatment and so truly changing these individuals for the long-term requires "hard work," as stressed by this participant.

Finally, responses that were unique to all participants from the residential settings was that change and improvement for people who sexually offend comes from providing education

and counselling that is tailored to their needs in order to promote skill development. One participant specified that counselling would have to be done over time in order for them to change and would take more time for an individual with a disability than for someone in the general population.

Offenders and deserving a second chance. Nine participants across the three settings stressed that people with intellectual disability and sexual offense histories deserve a second chance. The participants reported that these individuals have the right to effective, equal treatment, and rehabilitation. Six out of nine participants from all three settings identified that offending behaviour is due to factors such as poor boundaries, social learning history, cognitive ability, or brain injury, which can otherwise be explained by counterfeit deviance.

There were some differences in participant responses based on setting. In the transitional setting, all participants stated that due to the presence of a disability, the offenders do not know what is right and wrong unless they have somebody to guide them and teach them the difference so therefore they deserve a second chance. A participant from the transitional setting emphasized the right to effective treatment by stating that, "everybody deserves good treatment. Everybody deserves second chance."

Finally, one participant in the residential settings stated that sex offenders with intellectual disability have more rights than people in the general population due to their lack of understanding.

Intellectual disability and responsibility for behaviour. Participant responses to this question varied. Six participants reported that people with intellectual disabilities can be responsible for their own behaviour, one participant reported they cannot be responsible for their own behaviour, and three participants stated it is dependent on the situation and the level of disability.

One participant from the treatment setting illustrated a person-centered theme surrounding people with intellectual disability being responsible for their own behaviour:

> *...It depends on what type of disability, 'cause some of them can, some of them can't…You see when it comes to this field we have to be careful, it's not black and white…it depends on what we're talking about, what is the diagnosis? Individual basis, and they should be treated as such.*

Three out of four participants from the treatment setting elaborated by stating that people with mild intellectual disability can distinguish right from wrong, they have the ability to manipulate rules for their own interests, and under the law, people over 18 are considered adults and so they are accountable for their actions.

In the transitional setting, one participant emphasized that people with intellectual disability are responsible for their behaviour because if they have the ability to follow rules, then they have the ability to be responsible for their actions. Conversely, another participant stated that people with intellectual disability are not responsible for their behaviour because due to their limited understanding they "don't know what they are doing."

In the residential settings, two out of three participants believed that some people can differentiate right from wrong whereas others cannot foresee consequences or understand their actions and therefore, require education. One participant stated that people with intellectual disability clearly know what is right from wrong and so they are capable of making their own decisions.

Intellectual disability, sex offenders, and mutual, healthy, sexual relationships. All participants reported that people with intellectual disability who sexually offend are capable of having mutual, healthy, sexual relationships, however this is contingent upon factors that varied in participant responses based on setting.

In the treatment setting, all participants believed that being educated in relationship training and boundaries is integral to the achievement of a healthy sexual relationship, along with support and monitoring from staff. In addition, three out of four participants stated that people with intellectual disability and inappropriate sexual behaviour can achieve healthy, mutual, sexual relationships if they are able to self-manage by controlling any deviant sexual urges that might be present.

In the transitional setting, one participant viewed sex offending as a pathological issue and so providing the offender with sex education and encouraging relationships can fuel his sexual deviancy. In order to keep children in the community safe, it is best to try to suppress an offender's sexual urges, according to one participant. On the contrary, another participant stated that these individuals can have healthy relationships if they have staff support and a program in place that can equip them with strategies to help them deal with any problems they may encounter in the relationship.

In the residential settings, two out of three participants emphasized education, where offenders require more support and counselling in order to achieve this type of relationship. As one participant stated, "I think with proper counselling, proper understanding, um learning, life experience, they're capable of having normal healthy relationships down the road after much counselling…so it's just like any of us."

Finally, one participant in the residential setting noted that healthy sexual relationships could be achieved as long as the offender was willing to seek out partners in the appropriate age group.

Factors Impacting Support to Offenders

Within this section, the following topic areas will be reported based on participant responses: Factors that make the environment successful, factors that make the environment

unsuccessful, and a description of the supervision that is present in each of the participant's settings.

Successful factors. In the treatment and transitional settings, several factors were identified as being important to the success of an environment in supporting people with intellectual disability who sexually offend. Although it was not explicitly stated, it became clear from holistically analyzing the data from these two settings that 'success' refers to a lack of reoffending and an offender living safely in the community. As one participant from the treatment setting stated, "…once an offender always an offender, we are not here to treat or cure we are here to educate and help them understand their risk so they do not reoffend."

In the residential settings, the meaning of 'success' was different from the treatment and transitional settings. Through a holistic interpretation of the data, it was inferred that success for these participants was related to the offenders having a good quality of life, the presence of their rights, and the absence of problematic behaviours.

All participants across the settings identified that consistency was an important factor in making the environment successful. Consistency was noted by all participants in terms of routine and following rules and protocols. However, protocols were only present in the treatment and transitional settings and the definitions of rules and protocols were different depending on the setting. In the treatment and transitional settings, protocols referred to established procedures to follow that were in line with the offender's treatment or behaviour program. In the residential settings, rules referred to house expectations such as completing chores and respecting other roommates. Furthermore, participants from the treatment and residential settings were similar in their responses regarding consistency, where they stated consistency by having a low staff turnover rate is crucial to the success of the offenders. Three out of four participants in the

treatment setting related low-staff turn-over to consistency in following protocols since an increase in new staff can lead to more mistakes in accurately following protocols.

All of the participants in the treatment and transitional settings emphasized the importance of protocols and all participants in the residential settings emphasized the importance of house rules for a successful environment. Specifically, the participants in the treatment setting mentioned following a person-centered approach and having individualized protocols to match the profile of each offender.

The remainder of the successful factors identified by participants were not consistent across all settings. In the treatment and transitional settings, the team was the most prominent factor, with all participants in these two settings stating that it was the most important factor in having a successful environment. Specifically, the team must be compatible which naturally ensures an ability to cooperate with each other and maintain a well-working team. The common sub-themes within these two settings included displaying professionalism and having a strong collaboration between the front-line staff and management. In relation to the team, all participants from the treatment and transitional settings reported the importance of collaboration between front line staff and management through a bottom-up approach.

According to the six participants in these two settings, the management and the front line staff all work together as a unified team in order to provide the best support to the offenders, and one participant from the treatment setting described this view about staff-management collaboration: “I will not put myself in that position that some people are higher than me. Without me, there will be no them, without them, there will be no me. So we’re a team, that is what I always believe.” The participants frequently stated that they feel as if their voice is valuable and heard and they reported that this is crucial to the success of a team and consequently, the success of the offenders they support.

Participants in the treatment and transitional settings were also similar in their responses that community participation and inclusion are important. Participants in the treatment setting elaborated by stating that, in one benefit, this allows the offenders to practice using their self-management skills, while also serving as a test for the staff to determine if they manage appropriately in the community where target groups are likely to be present.

The remainder of participant responses to this question were unique to each setting. In the treatment setting, the participants expanded on the importance of the team by discussing commitment, fostering a culture of respect, being supportive of each team member, and communication.

Participants in the treatment setting emphasized commitment which was described as working to improve the offenders' lives, acting in the best interests of the offenders regardless of financial gain or time sacrifices, and commitment to protect the community from re-offenses. As one participant stated, "I think our heart is all in the right place for people working in this field, we are all on the same page as in wanting to better their lives and wanting to protect the community…"

Fostering a culture of respect was another theme strongly emphasized in the treatment setting as it was reported as being crucial to the success of a team working with people who sexually offend. This refers to reciprocal respect among all staff members where there is an absence of gossip, taking advantage, and talking behind other team members' backs. One participant described this culture as follows:

> *No politics. We always talk about it, what it is is that if there's any issue, we bring it on the table, no one is bigger than the team, you know? And that's how we resolve our conflict, we bring everything to the table rather than harbouring it and keeping it until it turns into a monster, we don't want that. It becomes a culture.*

Finally, in the transitional setting one participant stated that it is important to engage the offenders in activities within the home so that they can keep busy and avoid having offense related thoughts.

In the residential settings, all participants stated that caring for the offenders they support is important for the success of the environment. In addition, one participant stated that the staff team must be well trained and practice hypervigilance in order to avoid conniving tendencies by some of these individuals.

Unsuccessful factors. There were few similarities in participant responses to this question. Three out of six participants from the treatment and transitional settings stated that a lack of communication amongst the staff team would lead to an unsuccessful environment. In the treatment and residential settings, two participants mentioned the location, however the participant from the treatment setting went into more detail which will be described below. In the residential settings, one participant indicated that offenders should not be supported in suburban areas that are surrounded by homes that have children as this results in intrusive and excessive restrictions being placed on the offender.

The remainder of responses from participants varied and so they will be discussed uniquely to each location.

In the treatment environment, a prevalent theme was in regards to organizational policy and the importance of an agency recognizing that the treatment environment is a unique setting with a specialized population of people and therefore, warrants unique rules. According to two participants from this setting, certain policies and procedures that govern other group homes cannot be applied to the treatment home. Rather, participants stated that an agency must acknowledge that it is a specialized setting due to the high-risk and manipulative behaviours that

are present, and so treating this location according to its particular needs is key to success in supporting offenders.

Two participants in the treatment setting identified that currently living in a restricted, highly structured environment can be an issue when the offender moves on from treatment into a less structured, less supportive, and less supervised community environment. According to these participants, offenders may not have been able to learn all the life skills in treatment due to safety concerns, such as learning to cook, in order to succeed more independently in the community afterwards. In treatment, it is as if they are "living in a bubble" as stated by one participant. According to this participant, concerns are that the offenders will relapse once they are transitioned from a highly structured, supportive, rule-based environment in order to minimize risk to the community, to one that promotes a high degree of independence. It is this drastic contrast in transitioning that participants described will lead to a re-offense and so they stressed the need for a type of graduated system to a setting that is moderately structured, supervised, and supportive in order to minimize this gap in supports. Participants mentioned that this is difficult to achieve due to a lack of housing and staffing available to accomplish this within the agency. However, one participant stated that other agencies in the province need to "step up" and start providing support to these individuals because as it currently stands, most agencies will not accept these individuals into their agency. Participants reported that agencies turn these individuals away due to fear and lack of education on knowing how to support them. However, participants strongly emphasized that people can be trained to support offenders effectively and safely. As one participant stated, "yes you can do it, yes I did." This theme is prevalent throughout this analysis. According to the participants from the treatment setting, one way to achieve this learning curve is through good competent staff and lots of training, which will be addressed later in this analysis.

Furthermore, one participant from the treatment setting noted that a transition environment that is familiar to the offender but far away from prior offense locations must be considered. Offenders should also not be living in densely populated areas as this increases the number of environmental factors present that can aggravate a re-offense, according to this participant.

Finally, one participant stressed how staff members who lack objectivity and display an inability to maintain a degree of professionalism by responding emotionally to work situations, would be detrimental to environments supporting people with intellectual disability and sexual offending behaviour.

In the residential setting, there were some participant responses that were unique to this setting. The importance of community inclusion was commonly emphasized, as a lack of participation in events, activities, and employment would negatively affect the offender's progress and improvement, according to two participants from this setting.

Level of supervision. All nine participants stated that their settings have 24-hour staff supervision. However, the intensity of this supervision varied across settings. For instance, in the treatment setting, all participants described an environment that has 24-hour supervision with triple staffing, and an "eyes on" policy for the offenders. According to the participants, the staff always know where the residents are and this is assisted through the use of door and window alarms. Participants stated that this level of supervision is necessary due to their obligation to keep the community safe by restricting the offenders' access to potential victims.

In the transitional setting, participants stated that the home permits free access for all the residents, with staff doing periodic check-ins on the individuals' separate living areas. Two participants identified that the supervision level in the community is increased where the individuals are "eyes on" at all times in order to prevent access to potential victims. The

importance of the presence of increased supervision in order to prevent access to potential victims was a common response stated by three participants from the treatment and transitional settings.

Similar to the transitional setting, participants in the residential settings stated that although the offenders always have a staff within the home, they are not being constantly supervised. One participant described this:

> *Staff is here in the house with them. We aren't in the same room with them at all times, and we're not sleeping in the same room with them at all times, they can do their activities and do their own things and have their own independence, we promote their own independence in their own home.*

Contrary to the treatment and transitional settings, one participant in the residential settings described the level of supervision as being dependent on probation and court orders. According to this participant, if an offender is not on probation or under any restrictions from a court order, he can go into the community independently: "Out in the community generally he, if he said I am leaving I am going out, we can't force him to stay in right, but ah generally he understands that we're going out, we are going out together." However, in the absence of probation, two participants stated that the individuals they support attend community events and activities without supervision.

Structural Components of the Environment

Under this research question, participants described the surveillance systems, locking systems, house rules, and house responsibilities that may be present in their work setting.

Surveillance systems. Five participants from the transitional and residential settings stated that they do not have surveillance systems in their work setting. This was a direct contrast from the treatment setting, where all participants described cameras that are in every room of the

house except bathrooms and bedrooms, as well as alarms on windows and doors. All participants from this setting stressed that these systems are necessary, with themes that related to false allegations, safety, and increased supervision. Safety and increased supervision were the most prominent themes that were mentioned by all participants in this setting. According to these participants, the surveillance systems allow for staff to know where the individuals are at all times and monitor them to ensure the safety of themselves, other individuals in the home, and people in the community.

Locking systems. All participants stated that the settings have restricted areas that the residents are not permitted to access. These included offices, the laundry room, and areas that contain money and medications. The treatment and transitional settings were similar in participant responses in regards to locking up "sharps." All participants stated that sharp objects such as knives and forks are locked up and counted in order to keep track of potential weapons to ensure safety.

All participants in the treatment setting explained that the offenders have restricted access to certain areas of the home such as the kitchen, offices, and areas that contain their money, documentation, and medications.

The remainder of responses differed between participants in the treatment and residential settings. In the residential settings, the participants compared the locks to homes in the general population, as one participant stated, "we lock [the front door] at night so nobody can get in but nothing we wouldn't do at our own home." Furthermore, another participant confirmed that they "have locks just like any home."

In the treatment setting, all of the participants described an additional locking system that was unique to their setting. The participants described an electromagnetic locking system that is

on all the outside doors of the house. One participant explained why these "mag locks" are necessary:

> *[it] also supports staff when we say 24-hours eyes on, sometimes we're so busy doing something else and if the mag lock is not there, some of them like to elope to go and reoffend. And we have kids all over. So without that there is no way we can support them sufficiently, for the fact that, well you can do any other thing in this house but you don't have the access to go out when you want.*

House rules and responsibilities. All the participants stated that the individuals living in their setting have house rules and responsibilities that they are expected to follow and all of the participants believed these house rules and responsibilities are necessary. All participants stated that rules and responsibilities help teach skills and prompt individuals to learn community expectations. However, there was some variance in participant responses that were unique to specific settings.

In the treatment setting, one participant explained how house rules prepare the individuals for the community:

> *Before we say house rule, I think we should say community rule. It's what is not allowed in the community that we call house rules. Because they will be on their own one day and those things they will apply it while they're out there. Like you cannot touch anybody without asking in the community, same thing in this house.*

Furthermore, one participant from the treatment setting mentioned why it is important for the individuals to have responsibilities:

> *It's not because staff cannot do it but we don't want them to depend on staff for the rest of their lives because sooner or later they will go out and be on their own so we want those skills to go with them.*

In the transitional setting, one participant stated that rules and responsibilities serve to keep the offenders busy and occupied so that they are not thinking about offense related behaviours.

In the residential settings, participants identified that the rules for the offenders are very simple and basic, however all participants believed these rules are necessary in terms of providing structure and to determine the offenders' motivation level. In addition, one participant reported that rules are necessary because the offenders have a disability: "Primarily because [the] individuals that live here have intellectual disabilities obviously but they also have the mentality of younger than what they are." Providing rules that promote structure and teaching skills is an important factor for participants in this setting and according to one participant, "definitely offer them and provide them with choice and options because that's their right and we're strong with that, with the agency."

There was an evident dichotomy between participant responses in the treatment and transitional settings, and the residential settings. According to participants in the residential settings, the primary purpose of rules is to teach skills such as cooking, cleaning, and personal care. This is a direct contrast to the themes noted in the treatment and transitional settings. Where the treatment and transitional settings discussed the importance of rules from a safety and community protection standpoint, the residential settings discussed rules from the standpoint of teaching life skills. One participant from the residential setting solidified this point by stating, "our whole plan is to teach them life skills so that they are able to one day be on their own, and be providing everything for themselves."

Quality of Life and the Good Life for Offenders

In this section, the following interview questions will be reported from participant responses: the residents' opportunities to practice religion, their opportunities to hold

employment, their access to physical activity and exercise, whether family contacts are encouraged or discouraged, and the residents' participation in activities.

Opportunities to practice religion. All nine participants stated that the individuals they support are provided opportunities to practice their desired religion or faith if they choose. All of the participants across all settings identified that if the residents they support chose to practice a religion, they would make special accommodations to ensure they had the opportunity. There was one major theme from participant responses in the treatment setting that was not reported in the other two settings.

Although participants stated that they encourage the individuals to ask for support in practicing their desired faith, risks must be taken into account. For example, if the offenders cannot manage themselves when they see children at church (e.g. staring, talking to them), then they are no longer allowed to attend church with children. In addition, one participant stated that regardless of faith, the individuals may not be attending a church if they had previously offended at a church as this can lead to the offenders reliving their past offense and potentially trigger a re-offense.

Opportunities to access employment. All nine participants stated that the residents are provided with as many opportunities as possible to hold a job or make their own money, and some of the individuals within each of the settings have jobs. A response that was unique to all participant responses in the treatment setting was in regards to risk and requiring constant supervision. Along with an offender's choice in wanting employment, participants identified that a thorough assessment of the offender's treatment progress must be taken into account. This is a common theme among the participants and is illustrated clearly by one participant:

It's been some evaluation because number one, community safety is number one priority. Some of our [individuals] here we cannot expose them to sharps, we can't send them to a

job site where there are sharps, where they can be a danger to the community or themselves or to staff.

In the transitional setting, participants noted that opportunities for employment are important for the offenders they support in order to acquire new skills, to prepare for being in the community and meeting community expectations, and to feel a sense of community inclusion.

Access to physical activity and exercise. Every participant in the study stated that opportunities for physical activity and exercise are encouraged and available for the individuals they support in their setting. The rationale behind physical activity was consistent across all participants as well, where they all reported it is important to maintain a healthy lifestyle. Participants in the treatment and transitional settings stressed that exercise is a meaningful activity that keeps the residents busy and distracts from potential inappropriate thoughts. One participant in the treatment setting illustrated this point, along with emphasizing the importance of quality of life: "[Exercise] are (*sic)* part of living a healthy quality of life, it's a balance, food, rest, exercise. It helps because sometimes when you get engaged in exercise it takes away some of their frustration and stress."

Encouragement and discouragement of family contacts. All participants in the three settings emphasized that family contacts and other relationships are encouraged. However, the participants in the treatment setting provided detail to their responses that was not seen in the other settings, specifically stating that family is important for quality of life and as a protective factor. As one participant stated: "We consider it as part of the protecting factor that is help *(sic)* them succeed in life and here, except if such a parent has not been such [a] protective factor from the beginning." This quote leads into the theme of family contacts being discouraged due to the individual's choice, past history, family behaviour, and the relationship dynamic between the individual and their family. Recognizing that family may not be the best influence in the

offenders' lives was a prominent theme among the participants solely in the treatment setting. For example, sometimes there is a negative past history with family, and sometimes the offender or the family has decided they do not want to speak to each other anymore.

Encouragement of family contacts also extended into other relationships, where one participant from the treatment setting identified the importance of building friendships with people who are going to be a good influence on the offenders' progress during and after treatment:

> *At the end of the day you know by the time they leave here they are going to have friends anyways but making sure that such a friend is not going to have negative influence on the lives of the [individuals] so we monitor telephone conversations with friends.*

Participation in activities. Every participant in each setting stated that the residents they support participate in several weekly and community activities and events as well as other activities and hobbies around the house. Some of these activities were consistent across all settings and included sports, walks, festivals, board games, movies, and video games. The participants in each setting attested to the importance of participating in activities where community inclusion was a prominent theme in all of the participants' responses. One participant from the treatment setting highlighted this point well:

> *Yeah it's building their sense of community, you know. As an individual I would like to not just stay cooped in my house, I go to concerts, go to different festivals you know. I want the same thing for them too.*

Along with community inclusion, participants across the settings noted participation in activities as being an important piece of rehabilitation which is illustrated by a participant from the residential settings:

Just to get them out in the community and not seclude them, not keep them at home. Um, not to make them feel like they're constantly being punished for their past behaviours. Or what they have went (sic) through, it's very important. To see progression, to see improvement in their lifestyles and within themselves.

A major theme was identified in participant responses from the treatment and transitional settings that was not present in the residential settings. As much as participants believed these community activities are important, minimizing risk was a prominent factor in participant responses. For instance, depending on the community activity, the risks of potential recidivism may be too high for the offenders to attend. As one participant from the treatment setting explained, "You take them out of this setting, it's a different ball game when you're out there, you get to see the way they act, in public you know." In the transitional setting, minimizing risk was reported from different perspectives. One participant stated that these activities are important to reduce risks of reoffending because if the offenders are engaged in meaningful activities, they can keep their minds busy and refrain from thinking about offense related behaviours. Another participant in the transitional setting contextualized risk in a different format: "Eyes on them all the time [in the community]. Don't lose sight of them, anything can happen if you just take away your eyes out of there anything can happen."

Staff Training in Supporting Offenders

The following section will report on participant responses in the areas of the training they have received, the participants' opinions on the necessity of training in working with sex offenders, and whether or not participants desire any additional training that they have not received.

Training received. All participants in the three settings reported that they had received crisis prevention and first aid training. However, not all of the participants reported receiving the

same amount of training. In the treatment and transitional settings, all of the participants strongly articulated that they had received an abundance of training. Similar areas of training in these two settings that were identified by participants included behaviour management, basic medical training, and general education in intellectual disability. The participants in the treatment setting noted additional training that was not reported by participants in the other settings. This included risk assessment, behaviour analysis, criminal justice, and data collection.

Furthermore, the participants in the treatment and transitional settings reported that they had received additional training in sex offenders with intellectual disability, whereas the participants in the residential settings reported they had not received this type of formal training. One participant from the treatment setting stated, "[the agency] does give us a lot of trainings so we are kind of lucky with that. [They] are definitely putting the money into their staff I will say that for sure."

Conversely, participants in the residential settings stated that they had not received specialized training for working with sex offenders; rather it was more informal training which can also be looked at it terms of in situ learning. One participant from the residential settings described this training:

> *Um yes so again we, we were given the run down but the main thing is live and learn…We would, we knew [their] specific rules, what [they] could and couldn't do but everything else that comes with it we just you know, deal with it when it came, it was a learning experience type thing.*

Necessity of sex offender training. Eight out of nine participants responded to this question. Six participants stated that training in working with sex offenders is necessary, and this was the most prominent in participant responses from the treatment setting. Specifically, one participant from this setting stressed the importance of recognizing that the offenders can be very

mischievous and skilled at manipulation so training in addition to post-secondary education is crucial. All participants from the treatment and transitional settings stressed that working with sex offenders with intellectual disability is a specialized job that requires specialized skills, and so training increases competence for the job. Furthermore, one participant from the treatment setting described why common sense is not enough when working with this population, especially taking risk into consideration:

> *Why not is because we don't wanna set up the individual. We don't want to set them up for failure. So we need somebody who really knows about the program and can better support them. If you don't have the knowledge and you don't know anything about treatment the guys will take advantage of you and reoffend or do something, which means we're not protecting the community and then ourselves.*

This response was similar to a participant in the residential setting who recognized the increasing diversity of people in the community with challenging and unexpected behaviours:

> *To me it's a new world, I came to this field thinking, you know you work with people who have ID, who have Down's syndrome, who have those kind of classic conditions, and in the [time] that I've been here, things have changed significantly, I just never thought, I just wanna say I never thought I'd be working with someone who was a sex offender, so I definitely think it's necessary. It's not something they teach you in the program in school you know, so, no definitely.*

Finally, responses to this question took a different direction from two participants in the residential settings. One participant reported that training on the offenders' probationary guidelines is necessary as well as being aware of what to expect when working with sex offenders as it is not a match for all staff. Another participant from this setting stated that

training specific to working with sex offenders in their particular setting is not necessary due to the basic expectations required of the staff.

Desire for additional training. All participants in the treatment and transitional settings stated that they felt fully equipped with the training they had received and noted that they do not encounter any obstacles that they cannot overcome due to lack of knowledge and training. This response differed markedly from the residential settings, as all participants stated they would like to receive more training in working with people with intellectual disability who sexually offend. Specifically, the residential setting participants stated the desire to attend conferences and learn more about the research on other sex offenders in the intellectual disability population, along with learning more strategies and approaches and to gain more knowledge surrounding treatment for sex offenders. They reported this would lead to increased confidence in completing their job duties.

Three participants from the treatment setting mentioned they are always open to more learning and so they would like to learn more in terms of clinical work which requires additional schooling.

Staff Perspectives on Sex Offender Treatment

In the following section, participant responses on the efficacy of sex offender treatment and their opinions on treatment will be reported.

Sex offender treatment efficacy. All nine participants reported that treatment can work for people with intellectual disability who sexually offend. Four out of nine participants believed in treatment efficacy because they have witnessed offenders living successfully in the community after treatment. The remainder of responses differed among the settings.

Two participants from the treatment setting and one participant from the transitional setting were confident that treatment can work, however they identified that treatment efficacy is

contingent upon the presence of true deviancy (e.g. pedophilia) and offender treatment compliance or motivation. One participant from the treatment setting clearly described this contingency of treatment efficacy while recognizing that there are explicit situations that sex offenders must avoid, regardless of treatment success:

> *[Treatment] can help them to manage because if they did not have this opportunity their situation could have been worse, some could have been in jail you know, they would not have the opportunity to have a sense of inclusion in the community in which they belong. But with this kind of facility is (sic) really help them, after leaving they take whatever knowledge they have learned with them, it doesn't mean they can change completely, they cannot. Because I want to say ok, an [individual] has [transitioned] from here and then put your child, you want to put your child in the care of that kind of [individual], no! Because a (sic) pedophilia is always pedophilia.*

Thus, this participant believed that treatment cannot change the offenders but rather teach them to manage. This is consistent with the responses of another participant from the transitional setting. Another participant from the treatment setting mentioned the need for a multi-modal approach for treatment which should include medication, psychiatry, and different forms of therapy and counselling.

In the residential settings, two participants stated that treatment effectiveness depends on the offender's willingness to change, length of time in treatment and whether underlying issues are being targeted, the level of disability, and the presence of a disability. Specifically, these participants stated that treatment can be more effective for someone with a milder form of intellectual disability than for someone with a severe intellectual disability. Additionally, according to these participants, treatment is more effective for people in the general population than for people with an intellectual disability. One participant illustrated this:

I think that treatment can be successful in a sense for the individuals with intellectual disabilities but um, I don't necessarily think that it can be as effective as it could be with someone that's healthy, without a disability. I think they need a lot more treatment.

Opinion on treatment programs for sex offenders. Six out of nine participants expressed their enthusiasm for treatment programs for sex offenders with intellectual disability, whereas responses from the remaining three participants varied.

All participants in the treatment and transitional settings stated that treatment programs offer rehabilitation, community inclusion, and are important for community safety. However, one participant stated that treatment has its limits that need to be recognized because "[if the offenders] pass through treatment, [that] does not mean they cannot reoffend, they can still reoffend." Another participant explained the importance of treatment programs for sex offenders with a primary emphasis on the reduction of risk:

I think it's a program that keeps the community safe and the individual, instead of them being in jail not learning anything, not be given a second chance. So the program kind of pulled them out, gave them second chance, trained them and tried to support them and change their behaviour, teach them how to utilize what they have in a positive way.

In the residential settings, there were different opinions expressed about treatment programs, including that they need to be tailored to intellectual disability, more research in the field is required, and they can be effective for offenders depending on their level of disability. Finally, one participant reported that treatment can work depending on motivation: "I think that people have to want to have help. And if someone doesn't believe that they have a problem then how do you treat someone if they don't feel that way?"

Understanding and Adherence to Risk Management

In this section, the following questions associated with risk management will be reported on from participant responses: the use of drugs and alcohol within each setting, the use of prescribed medications for offenders in each setting, participants' opinions on how re-offenses may happen, whether the offenders understand the legal consequences of reoffending, and whether the offenders understand the social consequences of reoffending.

The use of drugs and alcohol. Six out of nine participants from the treatment and transitional settings emphasized that drug use is prohibited for the individuals they support. In the residential settings, two out of three participants stated that drug use is discouraged but the people they support "are adults…so they will make their own choices." Another participant illustrated this theme:

> *If they choose to leave the house and do drugs outside of the home and they're not supervised by us, then…we really can't do anything other than offer them counselling and you know, suggestions and try and deter them from ever doing that.*

In terms of alcohol use, six participants from the treatment and transitional settings stated that consuming alcohol is prohibited but it is dependent on the discretion of the psychiatrist and behaviour therapist. One participant from the treatment setting explained what would happen if the offenders were not on any medication and so the psychiatrist's input would not be necessary:

> *It is something we would still have to address because we don't know, is alcohol a factor for reoffending? Um how does the person's demeanour change with alcohol? So there is a whole lot of factors, I mean you have to look at history as well.*

All participants from the residential settings stated that the individuals they support can consume alcohol based on individual choice, but they try to impose a limit. As one participant illustrated: "We do allow [them] to consume alcohol at their own right. We do limit how much

intake they do have of the alcohol, based on their medications that they're on, and what's healthy and safe for them."

Sex offenders and the use of prescribed medications. All nine participants stated that the offenders they support are taking prescribed medication and seven participants believed medications are necessary. The remaining two participants specified that medication use should be individualized and dependent on each offender since, "each and every [individual's] situation is different, so some require medication to manage, some does *(sic)* not."

There were similarities and differences among participant responses in regards to the necessity of medications. All participants believed that medications are necessary to help manage escalating and inappropriate behaviours. Six participants from the treatment and transitional settings and one participant from the residential settings emphasized that medication is important because it helps to decrease deviant sexual urges. One participant from the treatment setting added that medication use requires an ongoing review by doctors to ensure its use is still justified. Furthermore, another participant from this setting clarified that medication is not seen as a "cure" where the individual will not offend due to the presence of medication but rather, it can assist them in managing behaviours more than without medication.

How do re-offenses happen? All participants across the settings were very confident that a lack of supervision would lead to a re-offense. Two participants from the transitional and residential settings stated that a lack of medication or using an ineffective medication could also lead to a re-offense. The remainder of the responses varied across settings, with participants in the treatment setting having the most dialogue about this question.

All participants in the treatment setting stressed that a lack of support would lead to a re-offense. Lack of support was described as not having enough responsibilities or activities in which to engage in the community. In addition, minimal staff supervision and diminished

monitoring to determine if offenders were staying on track with their risk management strategies were reported as factors that could influence a re-offense.

Further to lack of support is how participants in the treatment setting identified that insufficient assessment of the offenders can lead to improper supports for them out in the community, which can consequently result in a re-offense. For example, an inaccurate assessment may determine that an offender requires few supports and minimal supervision when, in fact, the individual requires intense supports and a high level of supervision. In the former the focus is on typical community living whereas in the latter the focus is on risk management. One participant reported that sometimes the offenders themselves can undermine their risks during assessments and make the therapists believe they are more ready than they actually are. In addition, another participant emphasized that there is no guarantee that when the offender leaves treatment the new supporting staff will continue providing the recommended supports to prevent a re-offense:

> *When someone leaves here we can only send them with the documentation that this is documented, this is character with staff support, we don't have that guarantee when they go by themselves. We don't. There is no documented support there.*

Thus, all participants in the treatment setting stressed that the offenders must receive ongoing support once they transition to a less restricted environment as this is strongly stated to impact reoffending.

Another prominent theme identified by all participants in the treatment setting was the environment, specifically in terms of victim access. All participants described the offenders moving from the controlled and locked environment in the treatment home to one that is uncontrolled and open in the community where they can easily access their target groups. A participant emphasized the certainty of a re-offense occurring if the environment was not secure

because the offenders are not ready to live independently: "Yeah they would offend, of course. Definitely. No doubt."

One participant from the treatment setting described treatment noncompliance as offenders expressing that they are not ready for treatment and they do not want to receive it. In this case, if an offender does not want to receive services from an agency and they are not legally bound to do so, they are able to refuse treatment and be in the community on their own. A participant explained that this situation would lead to a re-offense.

Finally, one participant from the treatment setting described organizational pressures where agencies are pressured to transition an offender out even if he is not fully ready to leave treatment because there is a long list of offenders waiting to receive treatment.

In the transitional setting, one participant identified staff complacency as a variable that would lead to a re-offense, where staff are not following protocols and are too "relaxed" with the offenders. Lastly, another participant from the transitional setting stated that offenders reoffend by mistake. They may do or say something that is misinterpreted as offensive or deviant so therefore they are labeled as a sex offender due to misinterpretations.

Some responses to this question were unique to participant responses in the residential settings. Extending the lack of supervision theme that was noted in all participant responses, two participants from the residential settings identified as a concern the inability to provide sufficient supervision, or a 'hands are tied' form of reasoning: "It is impossible for us to enforce anything if, um there is no court order or anything like that…if he says 'I am leaving, see ya', there is nothing we can do about it, see ya later." Furthermore, one participant described subtle actions by an offender that are used in order to appeal to children in the community as a way to increase their access. Thus, according to this participant, an offender who purposely attempts to gain access to children is at a high risk of reoffending.

One participant from the residential settings stated that an offense can occur due to chance because while out in the community, "anything's possible" and "we can't control that a hundred percent."

Finally, one participant discussed the disservice provided by the justice system in terms of failing to provide consequences for the offender's actions. For instance, according to this participant, an individual would reoffend because they know they can get away with it because they have a disability. In addition, the offenders may act impulsively where they will offend for instant gratification without thinking about possible consequences, according to a participant from the residential settings.

Sex offenders and understanding the legal consequences of offending. Eight participants responded to this question. Seven out of eight participants believed the offenders they support do understand the legal consequences associated with offending. All nine participants stated that the offenders know the consequences or could learn these consequences through education because they can reiterate these consequences when asked.

The additional dialogue surrounding these responses differed across settings. In the treatment setting, three out of four participants stated that the offenders display apathetic attitudes about reoffending which may share a strong connection to the reinforcing properties of committing a re-offense. For example, one participant stated, "they understand the legal consequences but my thing is at the point of offending, they don't think about the consequences at that time. The consequences, they probably think about it after the fact." This relates to the theme of impulsivity that was identified by these three participants who described that the offenders act before they think. One participant emphasized this point by stating, "they get something stuck in their mind and it doesn't matter, I have my target group in front of me…and I am going to touch them." Thus, these responses suggested that the desire to offend may be

higher than the desire not to offend; therefore the reinforcing properties of offending are higher in some individuals.

One participant in the treatment setting added that legal consequences are not an effective tool for the prevention of reoffending. This participant strongly believed that jail and punishment do not work because the offenders habituate to being sent to jail, leaving them with a "so what?" outlook.

In the transitional setting, one participant responded to this question. In contrast to a response in the treatment setting, the participant in this setting identified that jail is a deterrent and the offenders will "behave themselves" so they avoid going to jail.

Lastly, one participant in the residential setting believed that the offenders do not understand the legal consequences associated with reoffending. However, through an in-depth analysis of the data, it became evident that it was more a matter of not caring rather than not understanding: "He doesn't want to understand, so how do you force somebody to? He's only gonna listen to us if he wants to, and he doesn't wanna talk about it…so it makes it really difficult."

Sex offenders and understanding the social consequences of offending. Eight out of nine participants responded to this question. The eight participants were confident that the offenders they support are aware of the social consequences because they have been educated consistently and they are able to reiterate these consequences when asked. Three participants stated that the offenders they support have experienced the social consequences of offending first hand which has led to their understanding.

In terms of the weighting of these social consequences, two participants believed that the loss of friends, family, or a job are not serious consequences because the offenders will still see their family and their family will still be there regardless of them being in jail. One participant

stated that if they lose their jobs, they will still be provided for, which is not the case for people in the general population: "It's not a strong consequence, if they lose their job somebody is there to feed them…unlike me or you, if [I] lose [my] job, nobody [is] there to feed me so I have to be very careful at my workplace."

On the other hand, three participants identified social consequences as being more weighted than legal consequences because the offenders do not think about legal consequences but rather, relate more to losing family or friends. The feeling of being abandoned by family hurts more so for some individuals, social consequences have more bearing, according to these participants.

Similar to the question on legal consequences, five participants questioned whether or not the offenders think about these consequences prior to committing an offense and, if considered, whether the consequences overpower the desire to offend.

Practical Scenarios

In this section, participants' responses to five practical scenario questions are reported. The participants' responses are arranged based on setting in order to illustrate the variation in responses by setting.

Tim Horton's and kids' camp day. In retrospect, this question was ambiguous and open to different interpretations by participants; therefore its results need to be looked at with a degree of caution.

Five out of nine participants stated that they would not allow the offender to go to Tim Horton's, and four participants stated that they would allow them to go. The justification for these responses varied across settings and so they will be addressed under each setting.

Treatment. There were varying responses in the treatment setting regarding how staff should respond to this scenario, however they were all very similar in taking risk into

consideration. Half of the participants stated they would take the offender to Tim Horton's and half responded that they would not take the offender to Tim Horton's.

For the participants who stated that they would take the offender to Tim Horton's, this response was justified by identifying that it depends on how well they have been managing around children in the community. In addition, if the offender has been responding well to treatment, preventing him from getting into contact with his target group will not show the staff how well he can manage, and so this participant identified that this is a good opportunity for a test of the offender's self-management skills. For example, paying close attention to his verbal reactions and body language would determine if he could manage being around children and then this information would be documented. These participants stressed the importance of close monitoring and tight supervision while they were at the Tim Horton's.

The other half of the participants from the treatment setting reported that they would not allow the offender to go to Tim Horton's. These participants stated that they would outline to the offender that it is not a good time to go since his target group is present, therefore the offender can pick another day when there is less risk. One participant stated it is important to bring the question back to the offender and ask him why he should not be going as opposed to telling him. A high level of risk was identified in this scenario by one participant: "I mean, regardless of how well he is doing in his treatment, that is still not a good time to go. For sure it's a red flag that he wants to offend."

Transitional. All participants in the transitional setting stated they would not allow the offender to go to Tim Horton's during that time because there would be too many children present. According to these participants, a direct approach should be taken where the staff members clearly identify the offender's issues and why he cannot go there. Furthermore, protocols need to be followed which state that the offenders cannot go anywhere during times

when there are lots of children, but a participant also stated that individual discretion is important to keep the offender and the community safe.

An interesting finding in this question was that there was a marked difference among the treatment and transitional settings and the residential settings identified below. In the former settings, these participants clearly identified they would not be allowing the offender to go to Tim Horton's on his own.

Residential. There were varying responses in the residential settings, where some participants stated they would allow the offender to go to Tim Horton's and others stated they would not allow the offender to go while identifying limitations on imposed supervision. A common theme however, was that the participants would have conversations with the offender and talk him through whether he is making a good decision by going to Tim Horton's during kids' camp day.

For participants who would allow the offender to go, a hierarchy of responses was identified. First, they stated that they would have a discussion regarding expectations and whether it is a good idea to go to Tim Horton's. If the offender persisted and still wanted to go, the participants stated that they would attempt to go with him; for example, by stating they could purchase a coffee as well. One participant recognized that even though the offender has been managing well, it could be due to environmental control: "I would tell him you have been fine for a long time but have we put you in situations like this? Maybe you are fine because you haven't been put in situations like this." Therefore, a prominent theme was that this could be a "teaching moment" and a learning opportunity for the offender to use his skills. In addition, the staff could observe and see how he is managing in the situation and then use that information to determine future outings. In a situation where the offender says he wants to go to Tim Horton's on his own, participants commonly stated that if the offender is not on probation there is nothing

they can do but allow the offender to go on his own. One participant emphasized this by stating: "Yeah we can't do anything about it, if he reoffends, he reoffends."

On the other hand, a participant said they would not allow the offender to go to Tim Horton's during this time and would encourage him to go to places with people of his own age groups in order to prevent him from being in a situation that could make him reoffend. Similar to other participant responses, a participant described how they would handle an offender wanting to go to Tim Horton's during kids' camp day if he was not on probation:

> *...If he says to me during my shift, "I am going out in the community, I am leaving you, I'm going to Tim Horton's and I'm going to where I know there's a lot of children, I'm putting myself at risk and I don't care what you say," then we would just let him at this point leave the house, and like I said [if] he's got no court order, [if] he's never been convicted or charged, we would allow him just to leave and go at his own risk.*

This participant stated that if they had reason to believe he harmed someone after going to the community, they would immediately report it.

Violating house rules and refusing to listen. Three participants stated that they would review the house rules with the individual and seven participants stated that the offender would be facing some form of consequences. The remainder of the responses will be reported in more detail based on setting.

Treatment. Participants in the treatment setting commonly stated that if an offender they supported refused to follow rules and listen to staff, they would remind them of the rules and follow their protocols that identify what to do in these situations. One participant stated that many offenders go through a stage where they like to test limits and refuse to listen, and so having patience and consistency is key to getting through this time.

Furthermore, a participant believed that looking into the reasons why the offender is choosing not to listen or follow rules is an important area of investigation in order to help them through their issues, as well as to gauge their level of risk in the community:

> *If he is not managing well in the house, he is not going to manage well in the community. So we need to address his issues in the house and then like I said, I tell the guys if I don't trust you in the house to make good decisions, I cannot trust you in the community to make good decisions.*

Transitional. In the transitional setting, participants commonly stated that the house rules would be reviewed with the offender and then protocols would be followed in terms of how to deal with this situation which may include a decrease in their community outings. In addition, an appointment would be made for the offender to see his behaviour therapist to discuss potential underlying issues and the house rules may need to be changed or new ones put in place.

Residential. Two participants stated that they avoid conflict and arguments with the offenders they support at all times. These participants emphasized that they would aim to encourage reciprocal respect and instil consequences based on staff going out of their way for the offenders. For example, if the offenders they support are refusing to follow rules and listen, participants stated that they would not go above and beyond their job duties for them (e.g. taking them on special trips).

From a different direction, one participant stated that they would hold a team meeting and try to get to the root of the problem and determine why the offender is not listening and refusing to follow rules.

Experiencing a significant change. This question was intentionally ambiguous in order to elicit a broader array of responses from participants. Thus, participants answered in a variety

of different ways depending on what they considered a significant change (e.g. positive or negative).

Treatment. Participants commonly stated that depending on the type of change, they would talk and listen to the offender and provide them with appropriate counselling. One participant specified that they would include the entire team in the issue including the supervisor, behaviour therapist, and psychiatrist, in order to gain professional opinions on how to deal with the matter.

One participant interpreted the question from a much different direction, whereby staff should be made aware of any changes in the offender's life in order to prevent them from reoffending, and to provide continued support and follow-up after they finish treatment.

Transitional. A prevalent theme in the transitional setting was that the staff should consult their behaviour therapist or supervisor when there is a significant change in the offender's life and take direction on where to go from there. Furthermore, one participant stated that the way a significant change would be dealt with would depend on the individual offender.

Residential. All participants in the residential settings stated that they would provide the offender with informal counselling and try to help them cope and give them strategies to get through the change. Depending on the change, staff should celebrate with them, grieve with them, or provide help throughout.

Changed pattern of walking home through the park.

Treatment. Participants in the treatment setting stressed that this scenario is indicative of high risk that must be interjected immediately. Participants emphasized that protocols would be followed and this issue would be brought to the attention of the supervisor and behaviour therapist. As one participant stated, "if I see any straying away from normal routine, I will bring it to my supervisor and the therapist." Furthermore, a participant stated that if they were aware of

an offense happening, they would call the police. In addition to bringing the concern to the therapist and supervisor, a participant elaborated and said they would also review the offense history with the offender, and remind them of the pattern of how they offended before and how this situation may be similar.

Finally, a participant also included eliminating independent community access due to the increased risk that is presented as a result of the offender's poor choices:

> *...Eliminating his access now, to going on walks on his own, he will be walking with staff only, um and I think for the period of him having access outside should be like put on hold, to be by himself now because it is definitely a risk.*

Transitional. Similar to the treatment setting, the participants in the transitional setting emphasized that they would inform the behaviour therapist and follow protocols in order to ensure safety. In addition, one participant stated that the offender might have to go back to treatment because this may be an indication that they are not managing well in the community.

Residential. A prominent theme in participant responses in the residential settings was that the initial reaction to this scenario would be to communicate with the offender and ask him why he has decided to change his usual route, with one participant stating they would involve the supervisor and therapist. In addition, participants stated that they would be careful not to be accusing but rather, give him the benefit of the doubt (e.g. maybe he just wanted to try a different route). One participant identified that they would facilitate an open discussion with the offender, showing him how his new route may not be the best choice, while at the same time, respecting his rights: "You can't force them not to go through the parks so hopefully they make the right decision, if not then you have done what you can do, right?" Similarly, participants in this setting commonly made reference to respecting the offender's rights as exemplified in this scenario:

We would also communicate with him and ask him, you know, why he's decided to change that, and monitor it that way in the sense of not being too intrusive and going against his rights but at the same time, yeah just knowing what is going on.

With additional probing by the researcher, a participant stated that if the offender clearly said he is walking through the park because there are kids there, then they would see that as a red flag. The participant's response would be to continue communication and provide rules that were within his rights.

Finally, a participant added that it is important to continue monitoring the individuals even after they have been through treatment:

I get that the person's been through treatment and that's good but I think we still need to have some safeguards in place, I mean great you've been through treatment, you can go in the community, but we need to be checking in with him regularly…in my opinion.

Finding pictures of children in his bedroom. Seven out of nine participants stated that they would confiscate the pictures of children in this scenario. However, this response was mostly reported in the treatment and transitional settings.

Treatment. Participants in the treatment setting stressed that the initial response to this scenario would be to confiscate the pictures of the children, report to the supervisor and behaviour therapist, and increase supervision. All participants viewed this as a major lapse in the offender's management skills and one step before reoffending. As one participant stated, "it is now start of risky behaviours that can lead to offending behaviours…just to have those pictures in his room shows me that he is not managing, that he is retracting back."

Participants elaborated on the process they would follow, whereby one participant stated they would review the protocol for that offender and look at the issue with the entire team. Furthermore, other participants stated they would want to investigate how the offender was able

to access pictures, and another participant extended this thought by putting it back onto the staff and complacency by staff:

> *Maybe it's our fault as staff. Sometimes we think we know the individual and we just relax…so if we relax as staff sometimes they can sneak in pictures…when they come back from outing we do search them, but sometimes we're so confident, no he cannot do it, it's okay…so if we find pictures we want to know how (sic) they get the pictures from. If it's our fault for them to sneak it in, we increase supervision and then for such thing not to reoccur.*

Finally, a participant added that in treatment, they want the offenders to achieve full self-management by taking responsibility for their triggers and initiating their own self-management strategies. This participant provided an example of utilizing initiated self-management skills whereby if the offender attends a family party and there are too many children there, he informs his staff that he needs to leave. According to this participant, if an offender is achieving this it is a good sign that they are managing well.

Transitional. Participants in the transitional setting identified that this scenario is a serious occurrence that must be brought back to the therapist. One participant stated that they conduct room searches in order to keep the individuals safe from having objects that are not permitted. Furthermore, one participant viewed the offender having pictures of children on the same level of severity as an actual offense and stressed needing to go back to treatment: "Oh my god, that means he has committed the offense, he have *(sic)* to go back to the agency, he have *(sic)* to restart the program."

Residential. There were different directions taken by participants in the residential settings for this scenario which typically consisted of hierarchical responses.

In one sense, participants would have a conversation while giving the offender the benefit of the doubt (i.e. there may be a rational reason for having the pictures). In addition, one participant stated that the conversation would include supportive counselling from staff where they would encourage him to make good decisions. Similar to other responses by participants in these settings, if the offender is not on probation then the staff cannot force the offender to give up the pictures. However, this participant stated that the offender would be encouraged to make the right choice and remove the pictures but if he could not respect this, he would have to move out.

Likewise, a participant stated that after giving him the benefit of the doubt, they would provide the offender with counselling and involve the behaviour therapist in case they were heading towards a re-offense. In terms of confiscating the pictures, a participant stated that they would not take the pictures initially, but they were unsure of what would be the best action to take as they have received little training in this area.

A final direction in responses was that the pictures would be taken and reported to the therapist to determine why the pictures were in the offender's bedroom. This participant stated:

> *They do have the right to their own confidentiality and privacy I guess you could say, but at the same time if we know that there's something in this house that's at risk to them or others, we can take it, and that would be considered something in that category.*

Risk in the Context of Rights

After an inductive analysis of the results, major distinctions were drawn among all three settings in terms of the tone of the interviews from each location. A clear dichotomy was evident between the treatment setting and the residential setting, where the transitional setting sat somewhere in between this dichotomy. Specifically, the treatment setting was heavily focused on the importance of managing risks to the individual and the community, whereas the residential

setting was heavily focused on rights and normalization. The researcher noticed a difference in the language used in each setting, and so a word frequency test was run to determine the actual level of contrast among the settings. In terms of the word "risk" or "risks," the participants in the treatment setting used this word 54 times. Participants in the transitional setting used the word 6 times, and the participants in the residential settings used the word 11 times. A word query for the top 100 used words across all participants was conducted and displayed in a word cloud, as referenced in the following Figure 2.


able access activities actually agency allowed always another around away
behaviour call cant change children community
consequences definitely depends different disability done everybody
everything example experience family find first follow friends gentleman getting give
good group guys happen help history home
house important individual intellectual jail kids
learn leave life long look management medication members
necessary need offenders offending opportunity outside past
people person place program protocol question
relationship reoffend residents room rules second sexual somebody
someone sometimes specific staff stuff successful
supervisor support talk team therapist time training
treatment type understand want
week whatever within worked working wrong years

Figure 2. A word cloud of the top 100 most commonly used words with a minimum 4-letter length in all participants across three settings. Conjunctions and filler words were removed from the analysis. The larger and bolder words indicate an increased frequency of use by the participants. The word "staff" was the most cited word with 390 references, followed by home (350), house, (319), and people (300). Interestingly, "staff" was the most frequently referenced word which illustrates the level of influence the staff members have on the type and quality of support this population receives.

A text search query on the word "rights" was attempted to magnify how participants in the residential settings focused on this concept more than the other settings. However, this query was unsuccessful because participants commonly used the term as a filler word and the tone of rights evident in the settings was not commonly depicted using the specific word "rights."

Although the researcher noticed a difference in the risk and rights tone between the treatment and residential settings, the number frequency of words is not a complete accurate depiction of this dichotomy. The word frequency query was not an extensive search as it was specific to the term "risk," therefore it did not include words that depicted risk with the same meaning but different terminology. However, the text search query was beneficial as it gave the researcher the ability to narrow in on the theme of risk and gather a clear picture of the contrast among settings.

There was a noticeable difference between the use of the word "risk" in the treatment and residential settings (i.e. 54 versus 11), and the terminology of risk in the residential settings was sometimes unrelated to risk associated with sex offending. In the residential setting, the term "risk" was often used in the context of typical risk associated with group home living, as opposed to risk in the context of being a sex offender and the risk to the community. The discrepancy between the residential and transitional settings (i.e. 11 versus 6) suggests that there was less discussion of risk in the transitional than the residential settings. However, from examining the context of risk from a community safety perspective, participants in the transitional setting were actually discussing risk in this context more than the residential settings, just with different terminology. Refer to the following Figures 3, 4, and 5 for word trees depicting the frequency of the word "risk" in context in each setting.

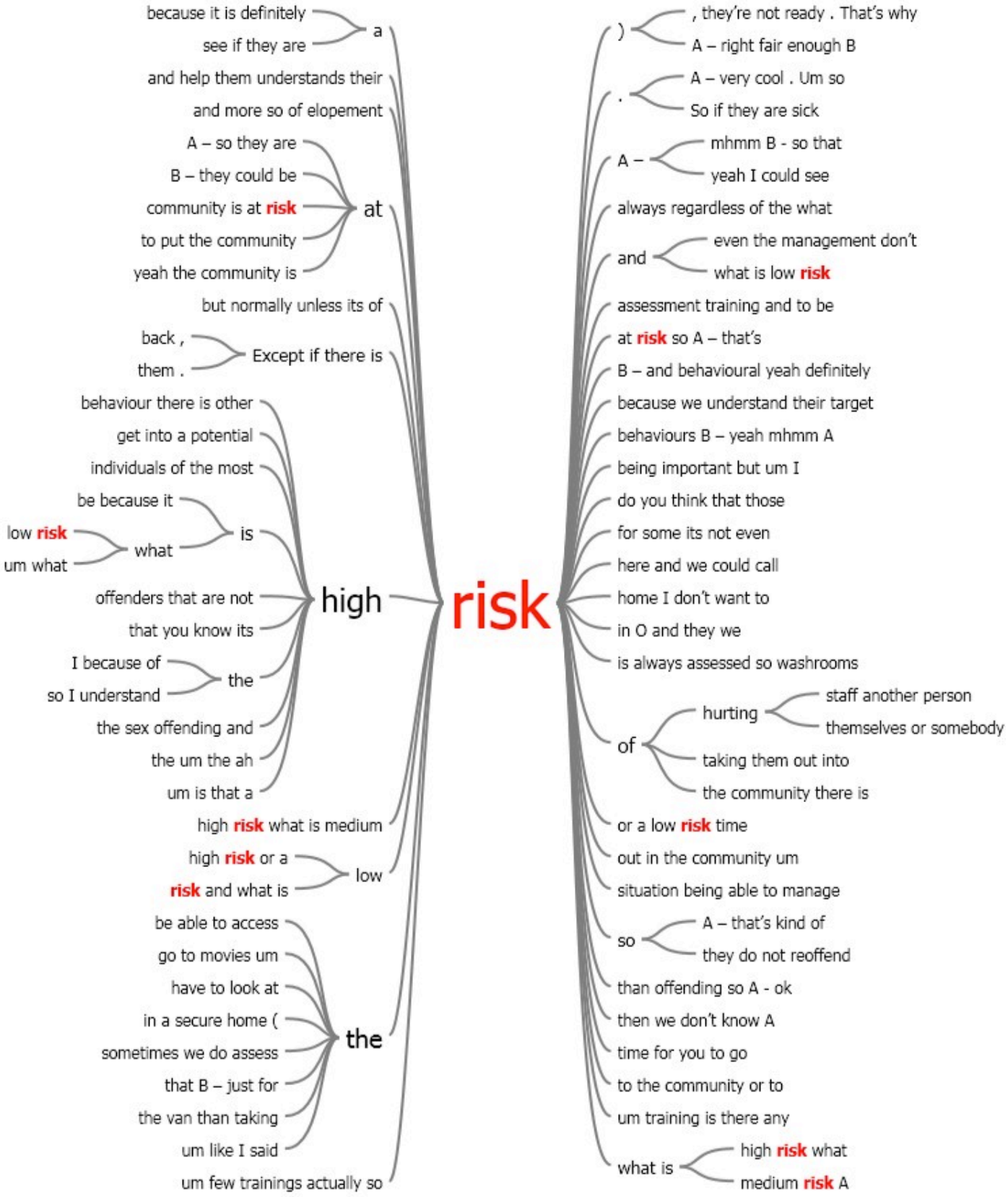

Figure 3. Word tree of the word 'risk' and its associated context in the treatment setting.

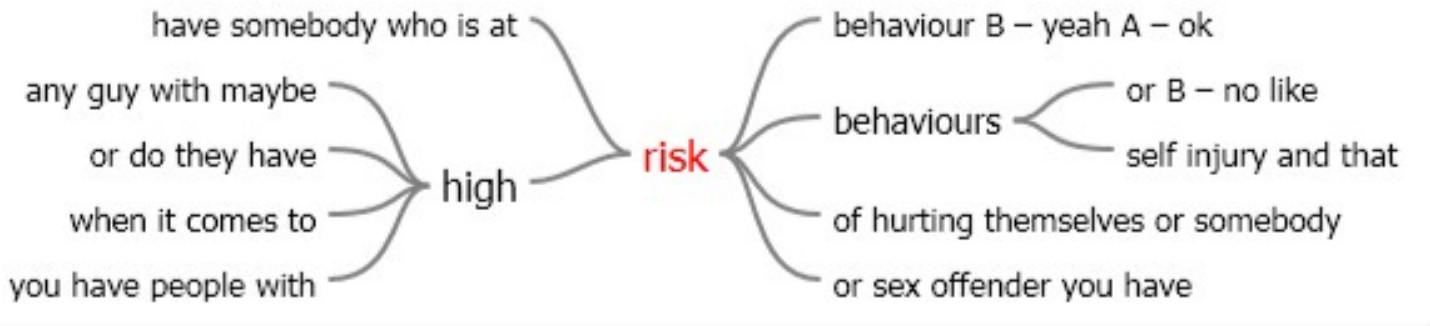

Figure 4. Word tree of the word 'risk' and its associated context in the transitional setting.

Figure 5. Word tree of the word 'risk' and its associated context in the residential settings.

An extension of this text search query through an additional comprehensive analysis provided results that showed the number of references to “risk” and “rights” from participant responses in each setting. A visual depiction of the balance of these references from participant responses can be viewed in Figure 6. It is important to note that the placement of the fulcrum can move depending on the individual offender, which is illustrated in Figure 7 (R. Wilson, personal communication, July 31, 2013).

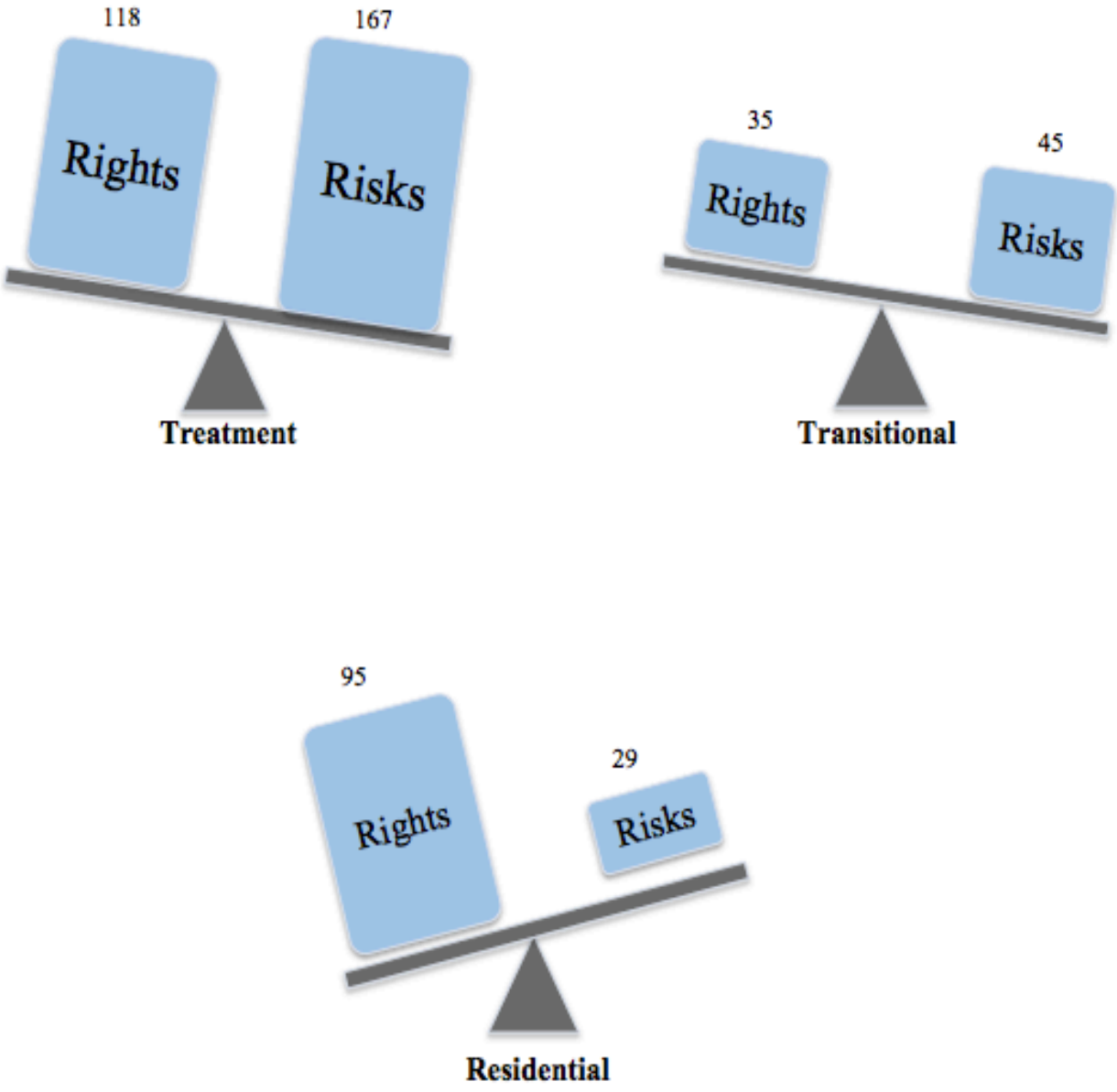

Figure 6. The balance of risks and rights from participant responses in the treatment, transitional, and residential settings. In the treatment setting (n=4), there were 118 references to rights and 167 references to risks. In the transitional setting (n=2), there were 35 references to rights and 45 references to risks. In the residential settings (n=3), there were 95 references to rights and 29 references to risks.

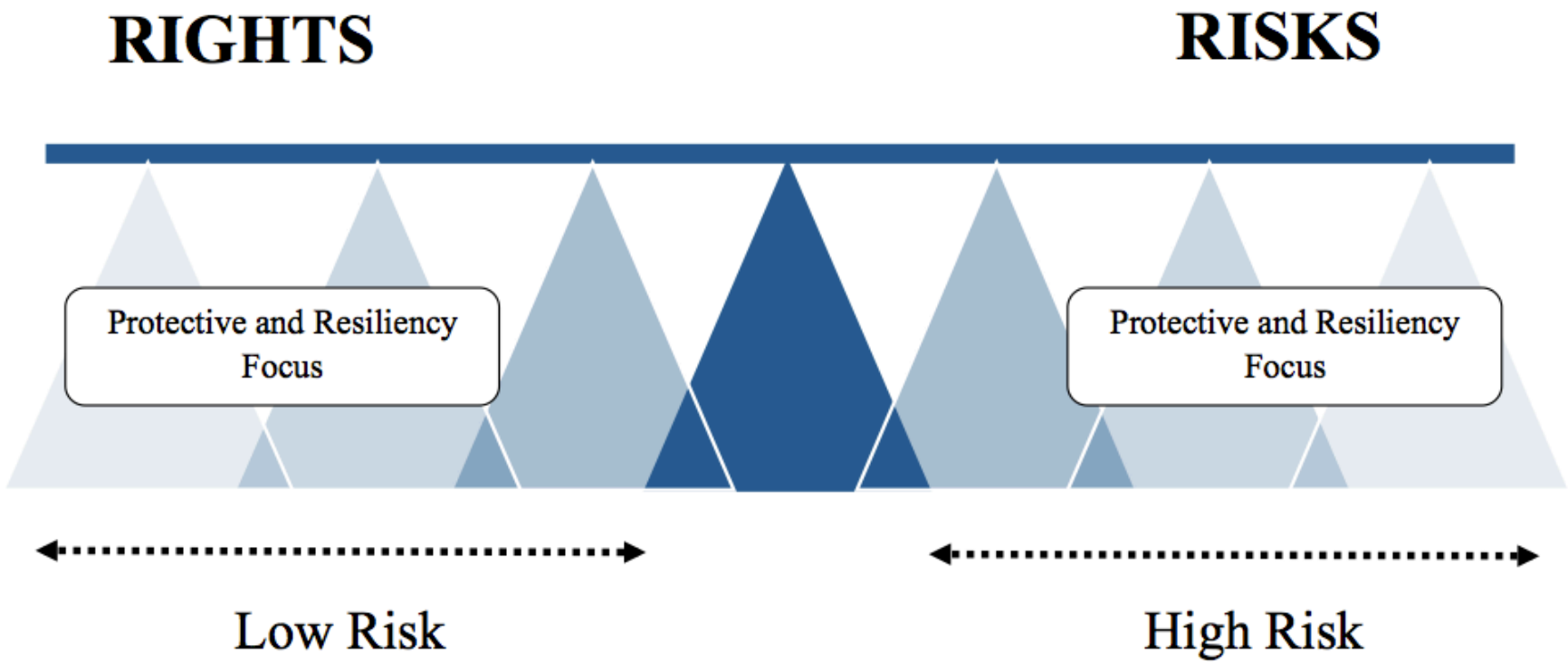

Figure 7. Balancing rights and risks requires a shifting fulcrum depending on the needs, risk, and responsivity factors of the individual offender.

The references to rights that were included in this analysis were identified from participant responses which were consistent with the literature on disability rights. Thus, references to rights across all three settings included the right to treatment, rehabilitation, relationships, person-centered supports, activities, enriched quality of life, choice, privacy, decision-making, confidentiality, community inclusion, independence, fair/equal treatment, and right to respect. The references to risk were identified from participant responses and included strategies to proactively minimize risk to the community, environmental conditions present to minimize risk, and identifying high-risk situations associated with sex offending and the risk to others. In the residential settings, participants identified risks that were typical of group living, household risks, and behavioural risks. These were not included in the results, as they are not associated with risks to the individual or the community due to high-risk sex offending behaviours. Therefore, only risks specific to the context of sex offending were included in the result figures.

Evidently, the criteria for participant references to risks and rights were different. A narrow description of risk was chosen because of the nature of the sample population; other risks would be present regardless of sex offending behaviour. These general risks (e.g. health risks, house safety) were not pertinent to the study whereas risk related to sex offending is more focused and involves high costs as it involves potential harm to others. Using these criteria for risk sets the precursor for the discussion on the balance of rights and risks in this population. On the other hand, the criteria for rights were more flexible and inclusive because rights are inherent to all human beings, irrespective of who they are or the offenses they have committed.

A stark distinction was evident between how rights and risk were presented across settings. In the treatment setting, rights and risk were commonly presented in a package and risk

was mentioned explicitly. For instance, one participant referred to community inclusion and activities while simultaneously considering risk:

> *Bowling ah September comes we bowl in [city] so those are two of the consistent things, um it's all a matter of choice for the [individuals] so if they don't want to do it then that's fine, obviously we have to take a look at risks as well in the community um we do go to movies um the risk is always assessed.*

Thus, in the treatment setting it was obvious that participants were thinking about rights but they were also thinking about risk. When discussed, rights were frequently talked about in the context of risk. In the transitional setting, rights and risk were also commonly presented in a package with an explicit mention of risks but not to the same extent as the treatment setting. The residential settings showed a direct contrast from the treatment and transitional settings. Participants in the residential settings frequently referenced rights without reference to risk. Further, risk was usually referenced in a vague and subtle manner, often subject to interviewer prompts. Thus, rights were commonly talked about but not in the context of risk.

Discussion

There are several key elements that emerged from participant responses that relate to the provision of effective support to prevent re-offenses in people with intellectual disability who sexually offend. The elements that emerged in this research are consistent with those found in the literature on dynamic risk factors for offending including the variables that fall under research avenues associated with risk assessment and risk management.

In the following section, re-offense variables that were discussed in the literature will be revisited and the results from this study will be discussed in terms of the various research avenues of prevention, proactive and responsive.

Prevention

Participants identified and described several dynamic variables that increase risk of recidivism and warrant intervention in the prevention avenue, according to the literature. These include stressful events and transition (Ward & Hudson, 1998) use of drugs or alcohol (Boer et al., 2004; Hanson & Harris, 2000), decreased supervision (Boer et al., 2004; Hanson & Harris, 2000; McGrath et al., 2007), access to target group (Boer et al., 2004), inconsistency in the staff routine, supervision, and staff approach, as well as hiring new staff (Boer et al., 2004). Further variables consistent with the literature from participant responses were a lack of a good life filled with purpose (Felce & Perry, 1995; Ward et al., 2007), a lack of resiliency (Dewhurst & Nielsen, 1999; Ward et al., 2007), few positive relationships (Hanson & Harris, 2000; Ward et al., 2007), minimal community inclusion (Lindsay, 2005), and limited coping skills (Boer et al., 2004; Quinsey et al., 1997).

Additional elements from this study were consistent with the literature on proactive and responsive avenues of risk management which will be illustrated in the following section.

Proactive and Responsive

Factors were identified in the results that are consistent with the literature that identifies an increased risk of reoffending. These factors included poor compliance with supervision, eloping attempts (Quinsey et al., 1997), lack of social support (Hanson & Harris, 2000), allowances made by staff (Boer et al., 2004; Lindsay & Beail, 2004; Lindsay et al., 2004), staff complacency (Boer et al., 2004; Craig et al., 2003; Lindsay et al., 2004), poor treatment compliance (Boer et al., 2004; Hanson & Harris, 2000; Lindsay & Beail, 2004; Lindsay et al., 2004), lack of motivation (Boer et al., 2004; Lindsay et al., 2004), anti-social attitude (Hanson & Harris, 2000; see also Lindsay & Beail, 2004; Lindsay et al., 2004; Quinsey et al., 1997), and the absence of a trusting rapport with supervisory staff (Boer et al., 2004). Additionally, the offender

resuming the old pattern of offending (Quinsey et al., 2004), displaying inappropriate behaviour (e.g. accessing pictures of children, pornography; Proulx et al., 1999; Quinsey et al., 2004), having a lack of open discussions with staff about target groups and risk, and choosing not to use coping skills (Boer et al., 2004) are more factors identified in the results that increase risk of offending.

Influence of the Environment

It is evident from the results that each environment supported the offenders in different ways. This finding further highlighted the fact that sex offenders with intellectual disability were living in systems that were easily susceptible to change. The most influential factor that affected the change and diversity in these environments was the staff members who provided supervision and support to these individuals. There were numerous responses about relapse and features of unsuccessful environments which were commonly associated with the staff and factors that can be manipulated by the organization. Therefore, according to the results this emphasized the need for staff training and dedicated staff members who view the offenders as people who require extra support. This can be achieved through displaying a positive attitude, believing that the offenders can improve, that they have the right to rehabilitation, and through working with the offenders objectively and without judgment. In order to create an environment that positively influences the dynamic variables that predict reoffending, it would be essential for elements to be embedded into the environment that promote risk management and building a good quality of life for the individuals. In other words, the Risk, Need, Responsivity (RNR) and the Good Lives Model (GLM) can be applied to offender treatment as complimentary approaches towards reducing offender recidivism.

Components of the RNR and GLM were evident in participant responses across all the settings. The level of understanding and adherence to risk management were illustrated

sequentially, where the treatment setting had the most discussion of risks, needs, and issues surrounding responsivity, followed by the transitional setting then the residential settings. The residential settings displayed the most lapses in terms of risk management. For example, in these settings, the red flags in the practical scenario questions that were indicative of imminent risk and required intervention were not identified. These red flags were commonly seen as behavioural issues rather than risk issues from an RNR perspective. Moreover, none of the participants identified the more subtle indicators of risk that were stated in the scenario questions (e.g. occurrence of a big change, refusing to follow rules). This is a large piece that is missing from the settings which the literature has shown drastically impacts offender success (Andrews & Bonta, 2007; Andrews et al., 2011). These lapses in identifying and managing risk along with some situations where the GLM and quality of life were not sustained are equally enlightening and valuable as the results that were consistent with the previously published literature. Further, these discrepancies provide a clear picture of where supports need to be improved and where the need principle of the RNR model is not being met.

Although the aforementioned factors that were consistent with the literature were found within the results of this research, they were not found equally across all settings. The presence of the GLM and quality of life models were evident in all settings, however the residential settings displayed a high emphasis of rights. In applying features of both the RNR and GLM models, participants in the treatment setting reported on a large number of variables in the literature on risk management, GLM and quality of life, participants in the transitional setting moderately reported on the literature in these models, and the participants in the residential settings minimally reported on factors in the risk management and RNR literature, and strongly focused on GLM and quality of life. Thus, although the RNR and GLM models can be seen as overlapping (Wilson & Yates, 2009), the implementation of these models was unevenly applied

and the settings were supporting these individuals in very different ways. In terms of applying features of RNR and the GLM, the treatment setting reported to be implementing these models the most, followed by the transitional setting, then the residential settings. Indeed, applying both of these models is synonymous with maintaining an equal balance of rights and risks while supporting individuals with high-risk behaviours.

Balancing Rights, Risks, and Responsibility

According to the literature, people with intellectual disability who sexually offend must be granted the same human rights as all people, while being cognisant of the public's right to safety and right to be free from harm (Birgden & Cucolo, 2011; Ward et al., 2007; Ward & Salmon, 2011). In this research, an unequal balance was seen across all settings, where the extent of the imbalance was more prominent in the residential settings than in the treatment and transitional settings. Specifically, in the treatment and transitional settings, there was more emphasis on risks than on rights. In the residential settings there was more emphasis on rights than on risks. This presents challenges since the residential settings are heavily focused on individual supports, autonomy, and rights, when this must be balanced with risks and responsibility. With the recent advent of rights-based training and movements across Ontario, the residential settings illustrated an over exuberance in the application of this newly applied concept. Human rights must be enforced, and this is consistent with building resiliency in the GLM and quality of life research (Dewhurst & Nielsen, 1999; Felce & Perry, 1995; Ward et al., 2007), but they must be regarded in the context of risk. It is creating an extreme disservice to the individuals and the community if rights and risk are not viewed as equally important separate entities. In the absence of this kind of balanced approach, which also encompasses a lack of fidelity in the implementation of the responsivity principle, people with intellectual disability who sexually offend may be insufficiently supported.

Future Research

This study revealed some important recidivism factors that were not commonly mentioned in the literature, yet are important for consideration when supporting offenders with intellectual disabilities in the community. These included issues at the organizational level, transitioning concerns, generalization issues, the importance of training, the issue of change versus improvement, deterrence and consequential learning, and the staff attitudes toward treatment and offenders. In addition, the results pointed to the need for community protocols so that there is a seamless plan for supporting offenders safely while they participate in community activities.

Organizational structure including mission statements, values, and policy played a large part in the diversity of these results. The staff who worked in agencies that had a more bottom-up approach reported the presence of strong teams and the necessity of teamwork. They emphasized the importance of the front line staff, managers, supervisors, and directors being equal players in the team. Therefore, future research should focus on providing support to people with intellectual disability and sexual offending behaviour at the organizational level, where the agency as a whole as well as the culture of the front line staff team are examined for how they impact the type and quality of support provided to these individuals. Additionally, the hierarchy of an organization and the values that the agency is trying to encourage should be examined for how that influences staff attitudes toward rights and risks as they relate to sex offenders. Finally, because all settings responded differently on what is acceptable staff-management collaboration, this is another area that should be the focus of future research. According to the results, staff-management collaboration leads to open communication and teamwork which subsequently creates consistency and structure which has been shown in the literature to reduce risk (Boer et al., 2004).

Further, an in-depth analysis of the participant demographics would have added an interesting component by determining if differences in responses were related to individual characteristics. These details could not be reported on in this study due to the small sample of people that were recruited from each location; producing such identifying information would have breached confidentiality. Thus, in any future studies of a similar nature, the education, training, age, experience, and gender of the staff members should be examined for comparative differences.

The type and frequency of staff training was a prominent theme which was identified as being crucial to providing sufficient supports to sex offenders with intellectual disability in the treatment and transitional settings. Therefore, not only should training about sex offenders and risk management be mandatory for staff working with this population, it may also be beneficial for future research to develop and evaluate selective training courses for staff in order to accommodate financial barriers that may be present in agencies providing training. In other words, presenting valuable training courses to agencies supporting this population may allow for a restructuring of funds towards specific useful courses. Since staff members play such an integral role in manipulating dynamic environmental variables, the level and amount of staff training may present as a risk factor that should be further explored.

The participants engaged in lengthy discussions on people with intellectual disability who sexually offend being able to improve or change. Participants viewed change and improvement differently and in some respects, improvement does not equate change. This issue presents a key point in regards to change that should be examined in further research. How is change defined, how is it measured, and how can one know when it has occurred? Additionally, how do these different views on improvement and change transcend into the quality and type of support provided?

There were varying opinions on the offenders supported and understanding the social and legal consequences of offending. Discussions arose surrounding the effectiveness of deterrence and consequential learning, which was beyond the scope of this study but is an area worth examining as a potential interrelated factor associated with reoffending.

This research displayed a strong emphasis on rights and risks and how there is an unequal balance across settings that support sex offenders with intellectual disability. There are numerous studies regarding duty of care and autonomy in the intellectually disabled population (Hawkins et al., 2011; Owen et al., 2003), but research on balancing rights and risks with high-risk sex offenders seems to be sparse. This field would greatly benefit from more research on strategies and suggestions of how to uphold human rights and a good quality of life for the offender, while still ensuring minimal risk to the individual and the community.

Many participants voiced concern regarding the degree to which offenders transfer skills learned in treatment to the community and whether they are able to generalize these skills without staff prompting and supervision, and when presented with potential high-risk situations. Thus, future research should examine skill generalization programs and how these can be incorporated into sex offender treatment for people with intellectual disabilities, without creating risk to the community.

As mentioned previously, there is a gap in the literature on influences of dynamic variables on the environments where people with intellectual disability who sexually offend reside. Therefore, this field could also benefit from more longitudinal research comparing environmental variables that are present in situations where offenses do not occur, versus settings where offenses do occur. Also, an important future study should explore the matching of individual needs to the setting. A discrepancy analysis could provide information on the offender's needs and what he currently has in place. This discrepancy between needs and the

environment may bring invaluable knowledge concerning the importance of matching the individual to the appropriate setting, including the disharmony and risk that can result from this mismatching.

Similarly, in order to achieve appropriate matching, risk assessments for people with intellectual disability need to be conducted in order to assess their level of risk and criminogenic needs. It is these initial assessments that aid in the matching of offenders to appropriate services and supports and so additional studies on validating risk assessments for people with intellectual disabilities would be highly beneficial for providing effective offender rehabilitation.

Lastly, throughout this study there are many references to building a "good life" for offenders that is consistent with the GLM by Ward and colleagues (Ward & Gannon, 2006; Ward & Stewart, 2003; Ward et al., 2007). Many people in the intellectually disabled population may not have the means or resources to attain a 'good life.' Rather than utilizing a preconceived idea of what makes a life good, perhaps future clinical work with offenders with intellectual disability should consider a reshaping of the conceptualization of a 'good' life to one that bestows a 'better' life.

Limitations

This research had a few limitations that may have impacted the results. First of all, a grounded theory design is limited in that it leads to a strict and rigid analysis. However, this was accounted for by combining thematic analysis to allow for a more flexible and in depth analysis of the results.

In addition, this research was exploratory and consisted of a small sample. Although the results of the study were enlightening, the findings cannot be generalized to a larger population. However, this study provided preliminary research in an area that is not commonly cited in the literature and introduces an important topic area to the literature that should be explored further.

Moreover, this research had a lack of triangulation since other forms of data collection, such as direct observations and focus groups, were not included in the methodology. Initially, direct observations were proposed for this research, however they were removed due to issues with obtaining consent from all staff and individuals who lived in each setting. In addition, the observations were not beneficial to the analysis since the interviews were very thorough and comprehensive; the direct observations did not add any new or supplemental information to the analysis.

Furthermore, the individuals with intellectual disability and sex offending behaviours were not included in the sample as a way of gaining their perspective on how they can be best supported. This person-centered approach would have been beneficial, however the subject matter covered in this research is a sensitive and stigmatized topic. Most individuals in this population do not feel comfortable openly talking about their offenses, especially with someone who is considered a stranger. To collect similar data on this research area through interviewing the clients would require a high degree of trust and rapport gained over time in order to uphold ethical and moral standards.

One of the agencies where the data were collected was from the researcher's place of employment. Although the researcher was not in a position of power or authority, this adds a limitation because it creates a potential bias in the data collection and analysis process. For this reason, research assistants unaffiliated with the agency were hired to conduct and transcribe the interviews so the researcher was blind to participants who volunteered. The researcher's own lens cannot be ignored; however it has been recognized through an author's perspective in order to elucidate how the data may have been perceived.

The results from this study suggest that based on the perspectives of staff who provide direct support to people with intellectual disability and sexual offending behaviour, these

individuals can be supported in the community as long as specific safeguards and variables are in place. Key elements that should be considered when supporting people with intellectual disability and inappropriate sexual behaviour include: staff members with a positive and objective attitude, clear rules and protocols, supervision and ongoing support, a staff team that employs teamwork, and an agency that collaborates with the front line staff and works alongside them as opposed to above them. In addition, consistency in protocols, staff approach, and low turnover were key to fostering a successful environment. Since variables such as staff turnover rate cannot always be controlled, thorough and comprehensive training on sex offenders with intellectual disability is crucial for all staff working with this population. Training on risk management variables is also important as it teaches the staff to recognize when risk is present and intervene accordingly and in a timely manner. Competent and properly trained staff increase the quality of care and support provided to these individuals, which consequently works to minimize risk of offending. Finally, environments that provide support to sex offenders with intellectual disability should be promoting protective factors through quality of life and encouraging a better life. This can be achieved by ensuring plenty of opportunities to practice religion, gain employment, partake in physical activity and exercise, have meaningful sustainable relationships, and participate in activities, hobbies, and community events. The rationale for building a better life full of protective factors for the offenders is to reduce the reinforcing properties of offending so that they have a life worth losing.

Though the participants were all supporting persons with intellectual disabilities who had sexually offended, the type of support provided was different across settings. For example, training received by participants was vastly different, where the treatment and transitional settings received sufficient amounts of training in working with sex offenders, the residential settings received minimal training. One response to these findings might be to suggest an

amalgamation of effective features from each setting, to develop a comprehensive support plan for this population. However, the type of environment and supports needed for a given offender can be vastly different from those required for another offender depending on the nature of the offender and the offense. This can be viewed from an RNR perspective where self-regulation and pathway followed, assessed risk, criminogenic needs, and individual characteristics can differ among offenders and therefore, warrant different levels of interventions. Comprehensive assessments should be conducted in order to determine the above variables so that the offender can be matched to the setting and proper supports and supervision. Thorough assessments should allow for proper clinical matching of the individual characteristics of the offender and their level of risk, and the type of environment that is needed. Each setting in this study was providing vastly different supports; the point that should be illuminated is whether these environments are suitable for the offenders residing in them. In other words, a high-risk offender displaying numerous risk factors should not be residing in a rights-based flexible environment that barely accounts for risks. An offender who is deemed to be at low risk for a re-offense and displays minimal risk factors should not be residing in a highly restricted environment that over accounts for risks and barely upholds rights. Therefore, a comprehensive assessment of the offender must extend into informing the structure and set-up of the environment and how it will manage rights and risks, according to the offender's profile. Finding ways to effectively balance rights and risks must be a priority in determining supports for an offender, as the uneven attention paid to these two variables can become an additional risk factor that exacerbates others that are currently at play. In future research, the suitability of the environment to support sex offenders in the community should be explored as a dynamic matching between the treatment and security needs of the individual and the capacity of the environment to provide the appropriate level of support.

Concluding Remarks

People with intellectual disability and sexual offense histories are being supported in community-based settings. However this research has illustrated that one type of environment does not necessarily suit all offenders. Social service agencies across the province have been shifting towards a person-centered approach where persons with intellectual disabilities have been recognized as people who require individualized supports and tailored environments. These values and missions need to be duplicated in supporting sex offenders with disabilities, where neither their rights nor risks become neglected. This notion of person centered planning must be applied to this population. It should be recognized that they too require thorough assessments to determine the type of environment and supports they need, taking into account their level of risk. In accordance with the RNR model (Andrews & Bonta, 2007, Andrews et al., 2011), supporting sex offenders in the community requires that extra step, where the risks to themselves and others are assessed (risk) to determine the appropriate level of supports (need) and how their rights and risks will be balanced (responsivity). In accordance with the GLM and building resiliency (Ward & Gannon, 2006; Ward & Stewart, 2003; Ward et al., 2007), environments must promote protective factors to build up a better life to reduce the reinforcing properties of offending and provide a life worth losing. Increased prosocial activities and relationships are incompatible with offending behaviour, highlighting the integral role that building a better life plays in reducing recidivism. Predominant aspects of the RNR model and GLM were evident across participant responses in all settings, and so an integration of these models may be best suited for supporting people with intellectual disability and inappropriate sexual behaviour in the community. This is consistent with the literature that notes the overlapping, complimentary features of these models and the importance of integrating these models to accommodate the complexity and multi-faceted issues that surround sexual offending behaviour (Wilson & Yates, 2009). The goal should be to

have a holistic view of the person and to provide an environment that best suits that person so they can have improvements in their psychological well-being and be successful. Fitting and individualized supports for these people can improve their quality of care, leading to a more enriched, meaningful life, while at the same time, keeping themselves and others in the community safe.

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Appendix A

Want to Participate in a Research Study?

Who am I?
My name is Stephanie Ioannou and I am a front line staff of this agency as well as a student at Brock University completing a Masters thesis.

What am I researching?
The title of my study is, Reoffending by Male Sex Offenders with Dual Diagnosis and Challenging Behaviour: An Exploration of Environmental Variables. I am currently looking at why someone with an intellectual disability who has sexually offended in the past would offend again during or after treatment.

What's your role in participating?
I want your professional opinion of what kinds of things can be done to support someone to prevent reoffending and what kinds of things can occur that can lead to someone reoffending. Two interviewers unaffiliated with this agency will ask you different questions in terms of your professional experience and perceptions about the environments that support sex offenders with an intellectual disability. The interviewer will be recording your interview so that the process runs quickly and smoothly.

You may be thinking, "She works here, something I say could be repeated within my agency!"
I will not be conducting the interviews, and I will not know who has volunteered to participate in this study. You will be contacting the interviewers if you want to participate, not myself. Names or any other identifying information will not be included on the interview forms. You will be referred to as, "Interviewee 1" and "Interviewee 2." I will not have access to the tape recordings. One of the interviewers unaffiliated with this agency will transcribe the interviews and then destroy the tapes immediately after. The transcriber will be instructed not to include any names or identifying information you may say in the interview. In other words, your participation is completely anonymous.

Well, what's in it for you?
You will receive a $10 gift card for Tim Horton's.

From participating in this study you are providing information that can potentially help support sex offenders with intellectual disability more effectively and thus, decrease the occurrence of reoffending.

If you can give about an hour of your time to talk to two individuals from Brock University in an anonymous way, please contact Courtney Bishop through email with times and dates you are available. Her email is **cw00ak@brocku.ca**

If you would like to speak with me directly, my contact information is 905-688-5550 ext. 5395, or si11er@brocku.ca. My faculty supervisor, Dorothy Griffith's contact information is 905-688-5550 ext. 4069 or dgriffiths@brocku.ca

The contact information for Brock University's Research Ethics Board is 905-688-5550 ext. 3035 or reb@brocku.ca. The Research Ethics Board clearance file number for this study is (#11-260).

Appendix B

Want to Participate in a Research Study?

Title of Study: Reoffending by Male Sex Offenders with Dual Diagnosis and Challenging Behaviour: An Exploration of Environmental Variables
Student Principal Investigator: Stephanie Ioannou, MA student, Applied Disability Studies, Brock University
Faculty Supervisor: Dr.Dorothy Griffiths, Child and Youth Studies, Brock University

Who am I and what am I doing?
My name is Stephanie and I am currently completing a Masters of Arts degree in the Applied Disability Studies programme at Brock University. I would like to invite you to participate in research for my thesis entitled, Reoffending by Male Sex Offenders with Dual Diagnosis and Challenging Behaviour: An Exploration of Environmental Variables.

I am currently looking at why someone with an intellectual disability who has sexually offended in the past would offend again during or after treatment. As a front line staff, you work with these individuals the most and know them best. Therefore, I want your professional opinion of what kinds of things can be done to support someone to prevent reoffending and what kinds of things can occur that can lead to someone reoffending.

What's your role in participating?
Should you choose to participate, you will be asked to provide about 60-90 minutes of your time to complete an interview with me. I will ask you different questions in terms of your professional experience, opinions, and perceptions about the environments that support sex offenders with an intellectual disability. I will be recording the interview so that the process runs as quickly and smoothly as possible. The interview will not be linked back to you in any way as no names or identifying information will be included in the interview.

Well, what's in it for you?
From participating in this study, you will receive a $10 gift card for Tim Horton's. You are providing information that can potentially help support sex offenders with intellectual disability more effectively and thus, decrease the occurrence of reoffending.

If you can give about an hour of your time to talk to me in a laid back, relaxed atmosphere, please contact me through email with times and dates you are available. My email is **si11er@brocku.ca**

My faculty supervisor, Dorothy Griffiths' contact information is 905-688-5550 ext. 4069 or dgriffiths@brocku.ca

The contact information for Brock University's Research Ethics Board is 905-688-5550 ext. 3035 or reb@brocku.ca. This study has been reviewed and received ethics clearance through Brock University's Research Ethics Board (file #11-260).

If you have any questions, please feel free to contact me.

Appendix C

Consent to Participate in a Research Study

Before you agree to participate in this research study, it is important that you read and understand the following explanation of the study. It describes the purpose, procedures, benefits, and risks associated with the study. All research participation is voluntary. You are free to withdraw at any time without penalty.

Title of Research Study

The title of this study is, Reoffending by Male Sex Offenders with Dual Diagnosis and Challenging Behaviour: An Exploration of Environmental Variables.

Purpose

The purpose of this study is to develop an understanding through the professional opinion of front line staff as to why sex offenders with an intellectual disability reoffend. The goal is to gather information on environmental variables that may either contribute to reoffending or deter someone from reoffending.

Description of the Research

If you agree to participate in this study, you will be asked to be interviewed one time for approximately one hour. A time to book the interview will be decided by yourself and the interviewers either at work or off site.

Potential Harms (Injury, Discomforts, or Inconvenience)

You can skip any question that makes you feel uncomfortable. There is potential risk to you if the confidentiality of the information you provide were to be lost. However, to protect your confidentiality, your name or any other identifying information will not be contained on the interview form. The agency may request a summary of the findings of this research study. The information in the findings will be anonymized.

Potential Benefits

For participating in this study, you will receive a $10 gift card for Tim Horton's. There are no other immediate benefits for you participating in this study. However, from participating in this study you are providing information that can potentially help support sex offenders with intellectual disability more effectively and thus, decrease future rates of reoffending.

Confidentiality and Privacy

The student researcher is a staff of this agency. However, I am bound by confidentiality by Brock University's Research Ethics Board. To further ensure your anonymity, the interviewer and transcriber are not affiliated with the agency in any way. Names or any other identifying information will not be written on the interview question forms; rather you will be identified as "Interviewee 1" and "Interviewee 2" and so on. The student researcher will not know who has volunteered to participate in this study. The student researcher will not have access to the tape recordings. Once the transcriber is finished taking notes on the interview, the tape recordings will be immediately destroyed. The transcriber will not make notes on any names or identifying information that might be stated in the interviews.

You can be assured that any information provided to the interviewer will not be repeated or linked back to you in any way.

In the event of an allegation of abuse, it is mandatory that the student researcher report this information in accordance with legal reporting laws.

Publication of Results

In the event that the results of this study are published or presented at conferences, seminars, or other public forums, no individual information or identifying information will be released. I will provide you with a summary of the results of the study after it is complete if you request one.

Reimbursement

You will not be paid for participating in this study. You will receive a $10 gift card to Tim Horton's.

Participation and Withdrawal

Participation in this research study is voluntary. If you choose not to participate, you will not be affected in any way. Your decision to participate or not participate in this research study will have no effect on you or your agency. If you would like to withdraw from this study, you can do so at any time by contacting Courtney Bishop at cw00ak@brocku.ca

If you choose to withdraw from the study, data already collected from you will be looked at to determine if it can still be used as it may provide valuable information to the study. If permission to use data that has already been collected is withdrawn then all the data collected from you will be expunged from the study. The paper data collected from you will be kept in a locked filing cabinet in a locked lab at Brock University and will be shredded no later than June 2014. The voice recordings will be kept in a locked filing cabinet in a locked lab at Brock University and will be destroyed immediately after transcription.

Study Contact Information

If you have any questions about this research study, you may contact myself, Stephanie Ioannou at 905-688-5550 ext. 5395 or by email si11er@brocku.ca. You may also contact the faculty supervisor, Dorothy Griffiths at 905-688-5550 ext. 4069 or by email at dgriffiths@brocku.ca

You may also contact one of the interviewers, Courtney Bishop by email, cw00ak@brocku.ca.

Research Ethics Board Contact

This study has been reviewed and approved by the Brock Research Ethics Board (File #11-260). If you have any questions or concerns about this study, you may call either of the investigators listed above or the Brock University Research Ethics Officer in the Office of Research Services at 905-688-5550 ext. 3035, email, reb@brocku.ca

Consent to Participate in a Research Study

I acknowledge that the research study described above has been explained to me and that any questions I have asked have been answered to my satisfaction. I have been informed of my right to choose not to participate in the study. As well, potential risks, harms, and discomforts have been explained to me and I also understand the benefits of participating in the research study. I understand that I may ask now or in the future any questions I have about the study or the research procedures. I have been assured that any information I provide will be kept confidential and that no identifying information that would disclose my personal identity will be collected in this study. I have been given sufficient time to read and understand the information pertaining to this research study.

By signing this consent, I agree to participate in this study. I also agree to have my interview recorded. I will be given a signed copy of this consent form.

X _____ _____

Signature of participant Date

Appendix D

Consent to Participate in a Research Study

Before you agree to participate in this research study, it is important that you read and understand the following explanation of the study. It describes the purpose, procedures, benefits, and risks associated with the study. All research participation is voluntary. You are free to withdraw at any time without penalty.

Title of Research Study

The title of this study is, Reoffending by Male Sex Offenders with Dual Diagnosis and Challenging Behaviour: An Exploration of Environmental Variables.

Purpose

The purpose of this study is to develop an understanding through the professional opinion of front line staff as to why sex offenders with an intellectual disability reoffend. The goal is to gather information on environmental variables that may either contribute to reoffending or deter someone from reoffending.

Description of the Research

If you agree to participate in this study, you will be asked to be interviewed one time for approximately 60 to 90 minutes. A time to book the interview will be decided by yourself and the interviewer either at work or off site.

Potential Harms (Injury, Discomforts, or Inconvenience)

You can skip any question that makes you feel uncomfortable. There is potential risk to you if the confidentiality of the information you provide were to be lost. However, to protect your confidentiality, your name or any other identifying information will not be contained on the interview form. The agency may request a summary of the findings of this research study. The information in the findings will be anonymized.

Potential Benefits

For participating in this study, you will receive a $10 gift card for Tim Horton's. There are no other immediate benefits for you participating in this study. However, from participating in this study you are providing information that can potentially help support sex offenders with intellectual disability more effectively and thus, decrease future rates of reoffending.

Confidentiality and Privacy

To ensure your anonymity, the interviewer is not affiliated with the agency in any way. Names or any other identifying information will not be written on the interview question forms; rather you will be identified as "Interviewee 1" and "Interviewee 2" and so on. Once the interviews are transcribed, the digital recordings will be immediately destroyed. Names or identifying information that might be stated in the interviews will not be noted on the transcriptions.

You can be assured that any information provided to the interviewer will not be repeated or linked back to you in any way.

In the event of an allegation of abuse, it is mandatory that the student researcher report this information in accordance with legal reporting laws.

Publication of Results

In the event that the results of this study are published or presented at conferences, seminars, or other public forums, no individual information or identifying information will be released. I will provide you with a summary of the results of the study after it is complete if you request one.

Reimbursement

You will not be paid for participating in this study. You will receive a $10 gift card to Tim Horton's.

Participation and Withdrawal

Participation in this research study is voluntary. If you choose not to participate, you will not be affected in any way. Your decision to participate or not participate in this research study will have no effect on you or your agency. If you would like to withdraw from this study, you can do so at any time by contacting Stephanie Ioannou at si11er@brocku.ca

If you choose to withdraw from the study, data already collected from you will be looked at to determine if it can still be used as it may provide valuable information to the study. If permission to use data that has already been collected is withdrawn then all the data collected from you will be expunged from the study. The paper data collected from you will be kept in a locked filing cabinet in a locked lab at Brock University and will be shredded no later than June 2014. The voice recordings will be kept in a locked filing cabinet in a locked lab at Brock University and will be destroyed immediately after transcription.

Study Contact Information

If you have any questions about this research study, you may contact Stephanie Ioannou at 905-688-5550 ext. 5395 or by email si11er@brocku.ca. You may also contact the faculty supervisor, Dorothy Griffiths at 905-688-5550 ext. 4069 or by email at dgriffiths@brocku.ca

Research Ethics Board Contact

This study has been reviewed and approved by the Brock Research Ethics Board (File #11-260). If you have any questions or concerns about this study, you may call either of the investigators listed above or the Brock University Research Ethics Officer in the Office of Research Services at 905-688-5550 ext. 3035, email, reb@brocku.ca

Consent to Participate in a Research Study

I acknowledge that the research study described above has been explained to me and that any questions I have asked have been answered to my satisfaction. I have been informed of my right to choose not to participate in the study. As well, potential risks, harms, and discomforts have been explained to me and I also understand the benefits of participating in the research study. I understand that I may ask now or in the future any questions I have about the study or the research procedures. I have been assured that any information I provide will be kept confidential and that no identifying information that would disclose my personal identity will be collected in this study. I have been given sufficient time to read and understand the information pertaining to this research study.

By signing this consent, I agree to participate in this study. I also agree to have my interview recorded. I will be given a signed copy of this consent form.

X _____ _____

Signature of participant Date

Appendix E

Interview Questions

1. How long have you worked at this agency?
2. How long have you worked at this location?
3. What did you go to school for? For example, which certificate, degree, or diploma did you obtain?
4. Why did you choose this job?
5. Do you see yourself in this line of work in 5 years? If no, why not?
6. On a scale of 1-5 (1= not at all, 3=somewhat, 5=very well), how well would you say you know or understand the residents in this home?
7. Do you think someone with an intellectual disability who has sexually offended can improve or change? Why or why not?
8. Do you think someone with an intellectual disability who has sexually offended deserves a second chance? Why or why not?
9. Do you think people with an intellectual disability can have a mutual, healthy, sexual relationship? If no, why not?
10. Do you think sex offenders with an intellectual disability can have a mutual, healthy, sexual relationship? If no, why not?
11. In general, do you think people with intellectual disability can be responsible for their own behaviour? Why or why not?
12. Do you like the sex offenders with intellectual disability that you work with?
13. What factors do you think make this home successful in supporting sex offenders?
14. What factors do you think would make this home unsuccessful in supporting sex offenders?
15. Are the residents in this home supervised? If so, how?
16. Are the residents in this home allowed to drink or do drugs? If so, under what circumstances?
17. Are there any surveillance systems in this home to monitor the residents? If yes, please describe.

18. Are there any locks or locking systems in this home? If yes, please describe.

19. Do you think house rules are necessary? Why or why not?

20. Does this particular location have house rules that the residents are expected to follow? If yes, what are they?

21. Do management and front line staff work closely together? How?

22. Are there any activities the residents participate in on a consistent basis? For example, certain activities on a weekly basis. What are they?

23. Do the residents participate in any community events or activities? If so, please provide some examples.

24. Aside from consistent activities, what other activities do the residents participate in?

25. Are family contacts and visits encouraged or discouraged? How?

26. Overall, with whom do the residents have relationships? For example, mom, dad, siblings, staff, outside friends.

27. Do the residents have access to physical activities and exercise? If so, please specify.

28. Do the residents have the opportunity to hold a job or make their own money? If yes, please specify.

29. Do the residents have the opportunity to attend religious services or practice their desired faith? Please specify.

30. Do the residents have any responsibilities around the home? For example, chores, grocery shopping, or others?

31. What kind of training have you received in order to work in this home?

32. Have you done any training specific to working with sex offenders with intellectual disability? If no, why not?

33. Do you think training on working with sex offenders with intellectual disability is necessary or unnecessary? Why?

34. Does working with sex offenders with intellectual disability require training beyond common sense? Why or why not?

35. Is there anything you would like to learn that you haven't been trained to do?

36. Can treatment work for people with intellectual disabilities who have sexually offended? Why or why not?

37. What do you think of treatment programs for sex offenders with intellectual disability?

38. Do you have experience following treatment programs, either in the past or present?

    If no, move to next question.

    If yes:

    a) Have you encountered any challenges when following the programs? If so, please specify.

    b) Do you follow the programs step-by-step or do you ever feel the need to modify them? Why?

39. Are the offenders you work with on any medication? Do you think they should be on medication?

40. Either in this home or in the past, have you ever worked with someone who has reoffended? (prompt: while you have worked with them?)

    If yes:

    a) Why do you think they reoffended?

    b) How do you think they were able to carry out the offense?

    c) Were there any changes either in the individual or environment preceding the offense? For example, behaviour changes, medical changes, change in routine.

    If no:

    a) Imagine someone in this home did reoffend. How do you think it would have happened?

41. Do you think the offenders you work with know and understand the legal consequences they would face if they were to reoffend? Please provide an example of how you know this.

42. Do you think the offenders you work with know and understand the social consequences they would face if they were to reoffend? For example, perhaps losing their job, friends, family, activities. Please provide an example of how you know this.

43. A man you work with who has offended against children in the past has been behaving and managing well for a long time. He asks you if he can go to Tim Horton's during kids camp day. How do you respond?

44. A man you work with who has a history of sex offending starts to violate house rules and refuses to listen to staff. How do you respond?

45. Someone with a history of sex offending experiences a significant change in their life, how do you think the staff should respond?

46. A man you work with who has a history of offending against children has completed treatment and can go in the community independently. As a staff, you notice that he started to change his usual path of walking home and began walking through the park. What would you do?

47. You work with an individual who has a history of offending against children but he hasn't had any issues with kids in a long time. What would you do if you found pictures of kids in his room?

Appendix F

Organization of Interview Questions Under Seven Major Research Questions for Data Analysis

Staff Attitudes in Supporting Offenders

4. Why did you choose this job?

5. Do you see yourself in this line of work in 5 years? If no, why not?

6. On a scale of 1-5 (1= not at all, 3=somewhat, 5=very well), how well would you say you know or understand the residents in this home?

7. Do you think someone with an intellectual disability who has sexually offended can improve or change? Why or why not?

8. Do you think someone with an intellectual disability who has sexually offended deserves a second chance? Why or why not?

9. Do you think people with an intellectual disability can have a mutual, healthy, sexual relationship? If no, why not?

10. Do you think sex offenders with an intellectual disability can have a mutual, healthy, sexual relationship? If no, why not?

11. In general, do you think people with intellectual disability can be responsible for their own behaviour? Why or why not?

12. Do you like the sex offenders with intellectual disability that you work with?

Factors Impacting Support to Offenders

13. What factors do you think make this home successful in supporting sex offenders?

14. What factors do you think would make this home unsuccessful in supporting sex offenders?

15. Are the residents in this home supervised? If so, how?

Structural Components of the Setting Environment

17. Are there any surveillance systems in this home to monitor the residents? If yes, please describe.

18. Are there any locks or locking systems in this home? If yes, please describe.

19. Do you think house rules are necessary? Why or why not?

20. Does this particular location have house rules that the residents are expected to follow? If yes, what are they?

21. Do management and front line staff work closely together? How?

30. Do the residents have any responsibilities around the home? For example, chores, grocery shopping, or others?

Quality of Life and the Good Life for Offenders

22. Are there any activities the residents participate in on a consistent basis? For example, certain activities on a weekly basis. What are they?

23. Do the residents participate in any community events or activities? If so, please provide some examples.

24. Aside from consistent activities, what other activities do the residents participate in?

25. Are family contacts and visits encouraged or discouraged? How?

26. Overall, with whom do the residents have relationships? For example, mom, dad, siblings, staff, outside friends.

27. Do the residents have access to physical activities and exercise? If so, please specify.

28. Do the residents have the opportunity to hold a job or make their own money? If yes, please specify.

29. Do the residents have the opportunity to attend religious services or practice their desired faith? Please specify.

Staff Training and Supporting Offenders

31. What kind of training have you received in order to work in this home?

32. Have you done any training specific to working with sex offenders with intellectual disability? If no, why not?

33. Do you think training on working with sex offenders with intellectual disability is necessary or unnecessary? Why?

34. Does working with sex offenders with intellectual disability require training beyond common sense? Why or why not?

35. Is there anything you would like to learn that you haven't been trained to do?

Staff Perspectives on Sex Offender Treatment

36. Can treatment work for people with intellectual disabilities who have sexually offended? Why or why not?

37. What do you think of treatment programs for sex offenders with intellectual disability?

38. Do you have experience following treatment programs, either in the past or present?

    If no, move to next question.

    If yes:

    a) Have you encountered any challenges when following the programs? If so, please specify.

    b) Do you follow the programs step-by-step or do you ever feel the need to modify them? Why?

Understanding and Adherence to Risk Management

39. Are the offenders you work with on any medication? Do you think they should be on medication?

40. Either in this home or in the past, have you ever worked with someone who has reoffended? (prompt: while you have worked with them?)

    If yes:

    a) Why do you think they reoffended?

    b) How do you think they were able to carry out the offense?

    c) Were there any changes either in the individual or environment preceding the offense? For example, behaviour changes, medical changes, change in routine.

    If no:

    a) Imagine someone in this home did reoffend. How do you think it would have happened?

41. Do you think the offenders you work with know and understand the legal consequences they would face if they were to reoffend? Please provide an example of how you know this.

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